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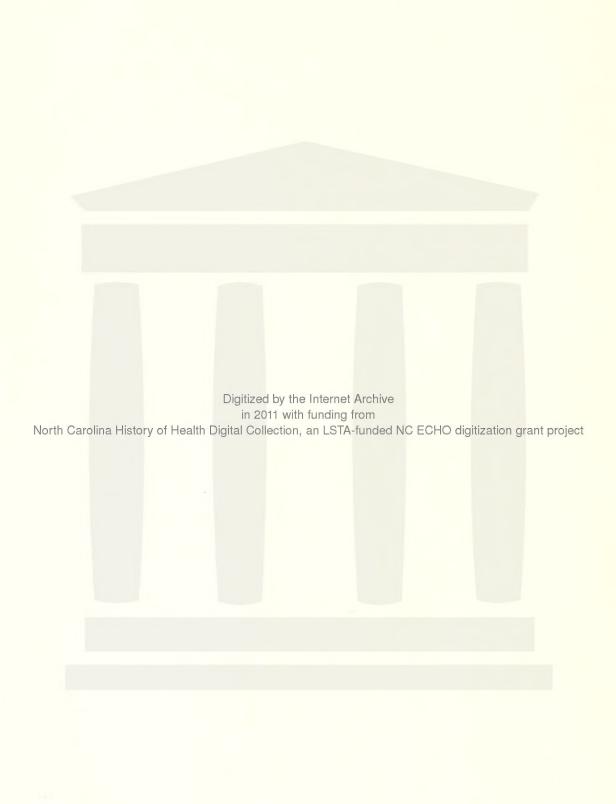
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IN THIS ISSUE:

Resuscitation in Anesthetic Accidents

LUTHER C. HOLLANDSWORTH, M.D.

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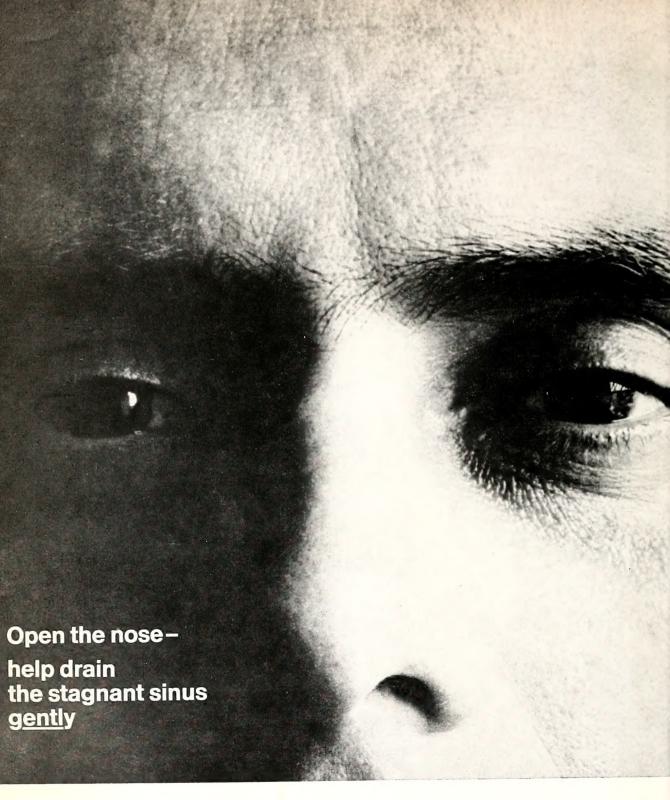
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*Proctor, D. F.: The Nose, Paranasal Sinuses, an Ears in Childhood, Springfield, III., Charles C Thomas, 1963, p. 34.

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Volume 27

JANUARY, 1966

Number 1

Resuscitative Efforts in Preventable Anesthetic Deaths

LUTHER C. HOLLANDSWORTH, M.D.

CHAPEL HILL

It would appear that the operating room should provide the ideal setting for the successful resuscitation of the patient suffering from cardiac arrest. He is literally surrounded by the necessary ingredients: trained and knowledgeable personnel dedicated to sustaining life; an intravenous route for the administration of fluids and drugs: a blood pressure cuff in place; and other monitoring, pacemaking, and defibrillation equipment at hand.

That this is not always the case, however, is evidenced by findings of the Committee on Anesthesia Study of the Medical Society of the State of North Carolina. It is the purpose of this paper to review the efforts at cardiopulmonary resuscitation employed in 102 deaths that this committee considered preventable from the standpoint of anesthesia. It is not the purpose of this work to consider in detail the various categories of errors that set the stage for cardiovascular collapse nor to argue the patient's right to a noble and dignified death. The paper is a plea for the right of a patient to live, a reminder of our legal and moral responsibilities to utilize accepted resuscitative measures, and a call to forego useless and maldirected polypharmacy, particularly when there is no circulation present to carry these drugs to their intended site of action.

Material

In the past three and one-half years the Committee on Anesthesia Study has sent out 675 questionnaires based on photocopies of death certificates made available by the Public Health Statistics Section of the State Board of Health. Three hundred fiftyseven of these questionnaires have been returned, in varying degrees of completeness. and form the basis of this report (Table 1).

Table 1 Material

Questionnaires Based on N. C. Death Certificates (October, 1961 - March, 1965)

Questionnaires mailed	675
Questionnaires returned	357
Deaths considered preventable	
By Anesthesia Study Commission	102
By submitting physician	29
Preventability questioned	
By submitting physician	11

From these 357 returns (a rate of 53%). 102 deaths were considered preventable. from the standpoint of anesthesia, by the Committee on Anesthesia Study. It is significant that only 29 of the deaths were considered preventable by the physician submitting the return, and another 11 physicians guestioned preventability.

Such a study has a number of limitations. First, only the fatalities are considered. No "near misses," morbidity, nor permanent impairment is called to our attention. Knowledge of some of the deaths reached us by very devious routes. Professional associates, other committees, and even the Fourth Estate have pointed out preventable anesthetic deaths that did not appear in our files.

In 1963 liaison was established with the Committee on Maternal Health in order to obtain information on preventable anesthetic deaths in obstetric patients. We have no statistics on perinatal mortality as it relates to anesthesia, but we received from the

Read before the Section on Anesthesia, Medical Society of the State of North Carolina, Charlotte, May 4, 1965.

Committee on Maternal Health six additional reports considered to represent preventable anesthetic deaths. Three of these occurred in 1963 and three in 1964; none of them are included in the present study.

Even though the coded and anonymous nature of this study is stressed, the compliance rate is only 53%. Ninety-seven of those who chose not to return the questionnaires clearly implicated anesthesia as the causative factor on the death certificate. This hesitancy on the part of physicians to submit information has been a rather uniform experience among the 23 functioning anesthesia study commissions or groups in this country.¹

Results

Reported errors

In the majority of the 102 cases included in this study, more than one factor related to the administration of anesthesia was involved (Table 2). The highest incidence of errors was found in the preoperative and postoperative care of the patient, each represented in 65 cases in this series. Mismanagement of the anesthetic course was implicated in 39 cases, and anoxia associated with anesthesia in 38. Thirty-two cases were felt to represent errors in the operative care of the patient, and 30 cases, overdosage of anesthetic agents. There were 25 errors in the choice of agent and 21 in the choice of anesthetic technique. These amounted to

Table 2 Causal Factors Related to Anesthesia

	No. Cases
Anoxia associated with anesthesia	38
Overdosage of anesthetic drug	30
Error in choice of agent	25
Error in choice of technique	21
Mismanagement of anesthetic course	39
Error in preoperative care of patient	65
Error in operative care of patient	32
Error in postoperative care of patient	65
Autopsy performed—28 cases	
No autopsy performed-73 cases	
Information lacking—1 case	

a total of 315 errors in the various categories and will be the basis of a separate study.

Of the 102 cases reviewed, autopsies were performed in 28 and omitted in 73. One other reply, as well as the accompanying

death certificate, did not state whether or not an autopsy had been performed (Table 2).

Administration of anesthesia

Table 3 summarizes the administration of anesthesia in these cases. In 81 the anesthetic was given by a nurse or nurse trainee.

Table 3 Administration of Anesthesia

Administrator	No. Cases
Nurse	77
Nurse trainee	4
Physician	13
Physician-anesthesiologist	7
Not known	1

In 20 cases the anesthetic was administered by a physician, in 13 of these by surgeons giving spinal or local anesthetics to their own patients, or by physicians engaging in part-time anesthesiology. One report listed the anesthetist as being neither a nurse nor a physician.

In this group of 102 patients, 15 were considered to be excellent risks, 10 good risks, 14 fair risks, and 63 poor risks. These four ratings of risk would compare closely with the class I, II, III, and IV ratings of the American Society of Anesthesiologists.² The classification employed here is incomplete in that it does not include evaluation of the emergency of the situation, classes V and VI of the ASA classification. Class VII, the moribund patient before operation, is included in our poor-risk category.

Use of narcotics

The cavalier employment of preoperative narcotics is reflected in Table 4, where it can be seen that the poor risk patient re-

Table 4
Use of Preoperative Narcotics

Risk	No. Patients	Narcotic Given	None Given	Per Cent
Excellen	t 15	12	3	80
Good	10	9	1	90
Fair	14	12	2	86
Poor	63	50	13	79
		_		
Totals	102	83	19	81

ceived a preoperative narcotic, in "routine dosage," with almost the same frequency as the remainder of the group. Two of the poor risk patients receiving narcotics preoperatively were described as moribund. Two others, of the large group of anemic and hypovolemic poor risk group, received norepinephrine (Levophed) drips only, preoperatively and operatively, to maintain blood pressure, after preoperative doses of morphine of 15 and 10 mg respectively. It is not the purpose of this paper to go into these errors in detail, and they are mentioned only to show how the stage has been adversely set for an attempt at resuscitation.

Resuscitative efforts

For our purposes, effectiveness of cardiac massage was described as the resumption of cardiac rhythm, even though temporarily, to maintain circulation. It is obvious that these figures are distorted in that cases of effective resuscitation in which the patient survives will never enter our files. This definition of effectiveness is much looser than that usually employed, and certainly than that of the Subcommittee on Closed-Chest Cardiac Resuscitation of the American College of Chest Physicians.³ Its criterion for successful cardiac resuscitation is the resumption of adequate circulation with no neurologic sequelae.

Table 5 summarizes the results of cardiac resuscitation in 48 cases. Resuscitation was not attempted in 52 cases, and in 2 others

Table 5
Effectiveness of Cardiopulmonary Resuscitation in Forty-eight Patients

Method	Effective	Ineffective
Closed-chest massage	9	27
Open-chest massage	5	4
Open-chest massage		
after failure		
of external massage	2	1
	$\frac{-}{16}$	32
Defibrillation (8 cases)	1 (open-c	hest) 4 (closed-
		chest)
		3 (Open-
		chest)

*In 2 additional patients resuscitation was attempted but method used and effectiveness were not reported on questionnaire or death certificate.

information was inadequate as to what measures were employed. There was "effective" resuscitation in 16 cases; in 9 by closed-chest

massage, in 2 by open-chest massage after closed-chest massage had failed, and in 5 by initial open-chest massage. Attempted resuscitation was ineffective in 32 cases: in 27 by closed-chest massage only and in 5 patients by open-chest massage, one of whom had received closed-chest massage initially.

Defibrillation was attempted in 8 cases and was effective in one instance of open-chest massage. In three other attempts at resuscitation, 4 by closed-chest massage and 3 by open-chest massage, defibrillation was unsuccessful (Table 5).

In this series, 3 major complications of cardiac massage were reported by the submitting physician (Table 6). One of these

Table 6
Major Complications of Cardiac Massage

	Number
Rupture of ventricle	1
Rupture of stomach	2
Total	3

was associated with open-chest cardiac massage when a ventricle was ruptured by a thumb. In 2 other cases, involving closed-chest cardiac massage, there was rupture of the stomach, determined a few days later at autopsy. Ironically, all three of these complications occured in good-risk or excellent-risk patients. Trouble begets trouble. Two reports indicated that the hospitals in question were not equipped with pacemakers or defibrillators.

Table 7 relates patient risk and resuscitative effectiveness. Of 15 excellent-risk patients, 5 were effectively resuscitated ac-

Table 7

Patient	Risk and Re	suscitation	n Effective	ness
Risk	No. Patients	Effective	Inadequate	Not
				Known
Excellent	15	5	7	1
Good	10	3	4	0
Fair	14	2	3	0
Poor	63	6	18	1
Totals	102	16	39	
rotars	102	10	02	2

cording to our very loose definition of effectiveness. Resuscitation was effective in 3 out of 10 good-risk patients, 2 out of 14 fair-risk patients, and 6 out of 63 poor-risk patients.

Inadequate resuscitation was a frequent finding in this study. In many of these cases closed-chest cardiac massage appeared to be a "mixed blessing" in that no effort was made to rule out ventricular fibrillation by electrocardiography when closed-chest cardiac massage was not effective. Thirty-two patients were considered to have received inadequate resuscitation, including 7 who were considered to be excellent-risk, 4 good-risk, 3 fair-risk and 18 poor-risk patients. One report in the excellent-risk group and one in the poor-risk group failed to give adequate information as to what, if any, resuscitative measures were carried out.

Table 8 Analysis of 52 Cases in Which Resuscitation

Was Not Attempted Resuscitation Resuscitation Patient Died on Omitted Indicated Table Excellent 1 Good 3 3 1 Fair 9 6 2 Poor 38 14 5 Totals 52 24

In 52 cases no efforts at cardiac resuscitation were reported (Table 8). When these cases were analyzed it was felt that in 24 cases cardiac massage was definitely indicated. In 8 cases death occurred on the table and in 16 cases was immediate to the surgical period. It was interesting to compare, on a chronological basis, the reports

Table 9 Chronology of Cases in Which Resuscitation Was Omitted

	Omittea	
Year		No. Cases
1961 (3 months)		2
1962		11
1963		6
1964		4
1965 (3 months)		1
Total		24

indicating that resuscitation was completely omitted. When it is remembered that 1961 and 1965 each represent only one quarter of a year in this report, there appears to have been a steady decline in cases where this was true (Table 9). Unfortunately, this observation does not apply to the reports of inadequate resuscitation on similar analysis.

Polypharmacy

Table 10 gives a summary of the polypharmacy administered in the operating room to 8 patients who died on the table without receiving indicated cardiac resuscitation.

Table 10

Polypharmacy in Eight Patients Who Died on Table
Without Indicated Resuscitation

Medication	No. Cases
Levophed drip	5
Adrenalin, intracardiac injection	2
Adrenalin, 1 ml IV	1
Aramine, IV	2
Vasoxyl, IV and IM	3
Neosynephrine drip	1
Neosynephrine IM	1
Wyamine, IV	4
Coramine, 1 ml IV	4
Emivan, IV drip	2
Cedilanid	2
Megimide, 1 ampule IV	1
Metrazol, 1 ampule IM	2
Caffeine sodium benzoate, IV	2
Solu-Cortef, 100 mg	1

Discussion

Although this 3½-year study has revealed 102 deaths considered by the Committee on Anesthesia Study to be preventable from the standpoint of anesthesia, the full magnitude of the problem is more fully appreciated when the unreported death certificates are reviewed. In this "no return" group are 97 certificates which clearly implicate anesthesia as the causative factor of death. If these were added to the present series, the total would be nearly doubled.

In considering the 32 cases in which inadequate resuscitation was involved, and 24
cases where resuscitation was definitely
indicated but not attempted, we have a total
of 56 cases—better than half of our total of
102. One physician considered closed-chest
cardiac massage "too heroic" a measure
after an elderly, anemic, moribund patient
had been subjected to all the Herculean hurdles at hand. In another case, nothing but
closed-chest massage was attempted because
"it produced a good pulse."

These examples reflect a very poor understanding of the role of cardiac compression. Cardiac massage, either by the external or open-chest method, is not necessarily the primary treatment for cardiac arrest, but serves merely to accomplish the first step toward resuscitation—that is, oxygenation of the myocardium and the brain.

The electrocardiograph must be available for adequate cardiac resuscitation, in order to detect ventricular fibrillation. In not one of the 32 case reports in which inadequate resuscitation was implicated was the use of electrocardiography mentioned. On the other hand, the limitations of the electrocardiogram must be kept in mind. Essentially normal complexes can be seen in the absence of cardiac output, carotid blood flow, or electroencephalographic activity. The electrical and mechanical events of the myocardium are not related in such fashion that cardiac output can be predicted from the electrocardiogram.

Administration of multiple analeptic and vasopressor drugs without some mechanical support of the circulation was also frequently encountered. Analeptics, such as Coramine, Emivan, Megimide, Metrazol, and caffeine sodium benzoate (Table 10) have little, if any, role in cardiac resuscitation. They are ineffective and may be harmful in the presence of ventilatory depression due to causes other than drug overdosage.⁴

The blind and empirical use of vasopressors (Table 10) in many cases will have an adverse effect on blood flow through various tissues. In cases of contracted blood volume, vasopressors tend only to aggravate an already vasoconstricted state. Tissue perfusion rather than a pleasing blood pressure should be the aim of therapy. One should treat the patient and not his blood pressure, and this involves determining the cause of the hypotensive state.

Continuous infusions of norepinephrine (Levophed) lead to tolerance and even reversal of action, due to desensitization of the vessels to circulating norepinephrine.⁵ Add to this an anoxic and acidotic tissue state and little can be expected from sustained norepinephrine therapy.

In no case of cardiac resuscitation was there mention of the use of sodium bicarbonate or molar lactate solutions. With the recognition that acidosis exerts such a deleterious effect on the circulation, correction of acidosis has been a significant advance in resuscitation.⁶ This may be accomplished by the use of sodium lactate or bicarbonate.

Dripps and his co-workers⁶ have described their most successful combination in resuscitating the "dying heart" as follows: (1) manual cardiac compression and myocardial oxygenation, (2) administration of sodium lactate, and (3) an infusion of norepinephrine.⁶

Rowe,⁷ studying the systemic and coronary hemodynamic effects of intravenous sodium bicarbonate in dogs, reported significant increases in blood pH levels, cardiac rate, cardiac output, cardiac work, coronary blood flow, and oxygen consumption by the heart and the body as a whole. These hemodynamic effects are not reproduced when the pH level has been elevated to the same extent by passive hyperventilation⁸ or when induced by THAM,⁹ but appear to be due to both ions in the sodium bicarbonate molecule.

In resuscitating dogs, the superiority of combining sodium bicarbonate with epinephrine over the use of either drug alone in the restoration of spontaneous circulation has been demonstrated. Person and Redding have demonstrated the same beneficial effect of sodium bicarbonate when combined with phenylephine.

During the period of this study an efficient external defibrillator has come on the scene, and it is hoped that this will lead to more successful closed-chest or external defibrillation.¹² It must be kept in mind, however, that neither drugs nor electric shock will be effective on an ischemic acidotic myocardium.

There were 28 autopsies in this series, a rather low figure for death under these circumstances. Autopsy findings will not help to differentiate the three most common causes of death on the operating table: blood loss, anesthetic overdosage, and asphyxia. However, there have been a few cases, four very striking ones, in which autopsy findings absolved anesthesia as a cause of death. Of 39 patients receiving closed-chest massage, 12 were subjected to autopsy, and 2

of these were found to have ruptured stomachs. In one of the latter there was extensive autolysis of the left leaf of the diaphragm and of the left lower lobe of the lung. These autopsy findings suggest the possible value of a routine flat plate x-ray of the abdomen following closed-chest cardiac massage and the passage of a nasogastric tube at the time of resuscitation to deflate the stomach and possibly obviate this major complication, if at all feasible.

Summary

On the basis of photocopies of death certificates made available by the North Carolina Department of Public Health, 675 questionnaires were sent to the attending physicians in the past three and a half years by the Committee on Anesthesia Study of the Medical Society of the State of North Carolina. Three hundred fifty-seven of these questionnaires have been returned, and among them 102 were considered to represent preventable anesthetic deaths. The limitations of such a study, and the various categories of errors involved, have been mentioned.

In better than one half of this series, 56 cases, there was either grossly inadequate cardiac resuscitation or no resuscitation at all, when it was felt to be clearly indicated. Lack of preparation appears to explain most of these inadequate resuscitative measures: preparation in the form of equipment and, most important, preparation on the part of the anesthesiologist or surgeon by which clear-cut, unmuddled course of action may be swiftly carried out.

Basically, this simplified approach amounts to (1) cardiac compression, either external or open-chest, to oxygenate the myocardium and brain; (2) correction of acidosis with either sodium bicarbonate or molar sodium lactate; (3) an infusion of norepinephrine; and (4) defibrillation, if indicated by electrocardiography. Adequate ventilation and correction of the precipitating factors are assumed.

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Anatomy, Botany and Chemistry and the Materia Medica are all branches of natural history, and are fraught with such amusement and utility that the man who entirely neglects them has but a sorry claim, either to taste or learning. If a gentleman has a turn for observation . . . surely the natural history of his own species is a more interesting subject, and presents a more ample field for the exertion of genius, than the natural history of spiders and cockleshells.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 16.

Respiration---Spontaneous, Assisted, or Controlled?

KENNETH D. HALL, M.D. DURHAM

As we progress in the science and art of anesthesiology we find ourselves being transformed from the role of the passive onlooker to that of an active participant in the physiology of our patient. The pioneers in our field developed unusually keen powers of observation and could detect slight changes in a patient's physiologic behavior that, unfortunately, many of us would miss today. It is a real tribute to such men as Snow, who successfuly administered that potent poison, chloroform, to thousands of patients, and to Guedel, who carefully catalogued the stages and planes of ether anesthesia, that they could safely produce anesthesia with a minimal control of the patient's physiology. Essentially all they did of an active nature was to increase or decrease the partial pressure of inhaled anesthetic gases. Since their day, anesthesiologists have encroached upon the ratient's physiology to the point where they now actively participate in, if not completely control, many of the body's functions, including the respiration, blood volume, metabolic rate (by regulation of temperature), hormonal balance, and circulation (both peripheral and central).

Our discussion today concerns the first of these functions: the respiration. "To breathe or not to breathe" for the patient is still one of the burning issues of our day; and if we are to "breathe" for our patient, how should it be done?

Definitions

First let us define spontaneous, assisted, and controlled respiration. Spontaneous respiration occurs when the total respiratory effort is made by the patient without outside help. This is known as active ventilation. Alveolar ventilation may be adequate,

inadequate, or more than adequate to maintain normal conditions. For example, if it is more than adequate, it is referred to as "active hyperventilation."

Assisted respiration occurs when the patient's respiratory drive is sufficient to maintain the respiratory rate, while the tidal volume (or depth of breathing) is augmented by outside help. This may be done in a number of ways; for example, by intermittent positive pressure applied manually to a breathing bag attached to a face mask on the patient, or by a tank respirator raising the thorax with intermittent negative pressure. Although this assistance or "augmentation" of the tidal volume is usually performed with each breath, it can be used effectively, under certain circumstances, with every other or even every third breath.

Controlled respiration occurs when the entire respiratory effort, including the respiratory rate and tidal volume, is performed by an outside force applied manually or mechanically. During this time the patient's own respiratory drive becomes dormant through a variety of mechanisms. The usual mechanism, however, is "passive hyperventilation," in order to avoid the stimulation of certain controlling mechanisms. An example is the depression of the respiratory center by a lowered pCO₂.

Advantages and Disadvantages

The advantages and disadvantages of assisted or controlled respiration as opposed to spontaneous respiration will be discussed together. Except in rare circumstances, assisted or controlled respiration is of benefit to almost any patient under major anesthesia unless it is improperly performed, in which case the advantages may become disadvantages. There are four main effects of augmented respiration: (1) increased alveolar ventilation; (2) improved circulation: (3) improved anesthesia; (4) a quiet operative field.

From the Department of Anesthesiology, Duke University Medical Center, Durham, N. C.

Read before the Section of Anesthesiology, Medical Society of the State of North Carolina, Charlotte, May 4, 1965.

Effect on alveolar ventilation

The principal purpose of augmented breathing is to increase alveolar ventilation. Alveolar ventilation depends on three factors: respiratory rate, tidal volume, and respiratory dead space. This can best be described by the simple equation (Fig. 1) below.

Fig. 1

Respiratory rate x (tidal volume — respiratory dead space) = minute volume (alveolar).

Within limits, increasing the tidal volume augments alveolar ventilation more than increasing the respiratory rate does. These limits are exceeded when overdistention of the alveoli produces no further increase in gas exchange but only an increase in respiratory dead space.

How could augmented respiration decrease alveolar ventilation?

- 1. When it is improperly done, the phasing could be off enough (approaching 180 degrees) actually to oppose the breathing efforts of the patient and thereby decrease alveolar ventilation. This occurs most commonly with inexperienced anesthetists and with improperly adjusted tank respirators.
- 2. A too "heavy hand" on the breathing bag, or a distended breathing bag that does not allow the intratracheal pressure to return to atmospheric levels will prevent the outflow of air from the lung (which is just as important as the inflow) and hence reduce the alveolar ventilation from what it would have been if one had just let the patient breathe spontaneously.
- 3. Another factor which would make assisted or controlled respirations deleterious to alveolar ventilation is an obstructed airway. This is most commonly seen in asthmatic and emphysematous patients. In some of these patients, the slightest increase in intratracheal positive pressure will occasionally cause obstruction at the bronchiole level. In this case, spontaneous respirations will actually provide better alveolar ventilation than would any attempt at augmentation. Rarely, patients are seen with mediastinal masses encroaching upon the trachea in such a way that a positive intratracheal pressure will, by torsion or bending of the trachea, worsen the obstruction. These patients also breathe better without outside help.

4. Another instance of decreased alveolar ventilation with augmentation is encountered in the patient with a tension pneumothorax. Here the mechanics of breathing are interrupted by "pumping" air into the pleural space. These patients must be allowed to breathe spontaneously until the chest is open or a chest catheter is inserted and attached to some sort of suction.

Effect on circulation

Augmented ventilation will improve the circulation indirectly by preventing asphyxia to the heart and blood vessels. Some have suggested that overventilation, by lowering the pCO₂, causes vasoconstriction of the small vessels, particularly in the brain, thereby achieving local tissue hypoxia from stagnation. This is a controversial subject, however, and most investigators today believe there is little, if any, such effect. There is no question that sudden shifts in ventilation, such as from chronic hypoventilation (minutes to hours) to marked hyperventilation, may cause cardiovascular collapse. mechanism is not well understood but probably relates to shifts in the pCO₂ and serum potassium levels. It is sometimes referred to as "post-tracheotomy shock," since it is frequently seen upon the release of a chronically obstructed airway with the ensuing active hyperventilation. For this reason, in patients with chronic obstruction ventilation should probably be increased gradually.

The direct effect of augmented ventilation upon the circulation is related principally to the transmission of intrathoracic pressures to the vena cava and to the heart itself during diastole, and alveolar pressures to the pulmonary capillary bed. If these pressures are high, the vessels collapse and blood flow through them decreases. The

effect is similar to right heart failure. If the pressures are low, the vessels distend and blood is pulled into and pooled in the thoracic area. This effect is similar to left heart failure.

These effects can easily be demonstrated by exaggerated Valsalva and Müller maneuvers. Clinically the Müller maneuver is seen in the patient in a tank respirator, with a partially obstructed upper airway. Here with each stroke of the piston a negative pressure is applied to the thorax, transmitted to the pleural space and maintained, because air cannot flow fast enough through the trachea to equalize the intra- and extrapulmonary pressures. Blood flows into the thorax and pools in the vena cava, right side of the heart, and pulmonary bed, resulting in pulmonary edema.

The Valsalva maneuver is seen even more commonly during anesthesia. Here, too great a positive pressure during inflation, too long a duration of inflation, or too great a positive pressure during deflation will all contribute to an increased mean venous pressure. In infants and hypovolemic patients, this is a particularly effective way to reduce the effective circulating blood volume. If, however, a properly applied and properly phased alternating positive-negative pressure can be applied to the trachea, the foregoing effects can actually be used to augment the circulation. Blood is drawn into the chest during the negative phase and pumped out during the positive phase. This is seen clinically with carefully regulated respirators. Cardiac arrest has been produced experimentally in animals and effective circulation then maintained with alternating positive-negative tracheal pressure. This phenomenon deserves more investigation.

Effect on anesthesia

It has been observed clinically for many years that patients who were passively hyperventilated required less anesthetic to be maintained in a given plane of anesthesia than if they were breathing spontaneously. Whether this is a form of hypnosis, exhaustion of afferent stimuli to the reticular activating system, alkalotic narcosis, or what,

has not yet been determined. It has been observed, however, that the regularity or rhythmicity is just as important as the absolute increase in alveolar ventilation. For this reason some anesthesiologists advocate the use of mechanical synchronous respirators rather than "hand bagging." seems to be very little harm in deepening anesthesia by this method, and the effect is instantly reversible by stopping the hyperventilation. The novice should not, however, confuse this increase in the depth of anesthesia with that due to a higher concentration of gaseous anesthetics in the blood associated with passive hyperventilation. The latter is due primarily to better aeration of the alveoli with the anesthetic gases, and hence more rapid absorption into the blood. (The slightly increased positive pressure might also contribute, owing to the increase in the partial pressure of the gases. This increase at the alveolar level, however, is usually very small.)

Effect on the operating field

A quieter operating field can be obtained with the properly assisted or controlled respiration. This will reduce the arterial pCO₂, which in turn reduces abdominal muscle tone. It also reduces the diaphragmatic flap, which is the consequence of a high CO₂ level. Most important, however, it produces an even, quiet, and rhythmical expansion of the chest. Obviously, improper phasing and pressures will be detrimental rather than helpful in this regard.

Indications

When should assisted or controlled respiration be used? Respiration must be augmented whenever there is any decrease in respiratory function that can be corrected by this means. It may be augmented whenever the supplementary advantages of improved circulation, anesthetic level, or quiet field are desired.

When is respiratory function decreased? First, we should rule out those conditions in which respiratory function is impaired and increased ventilation will not *primarily* improve the situation:

1. Obstruction of the airway.

- 2. Certain disruptions of the lung-thorax system (tension pneumothorax).
- 3. Uneven blood flow in the pulmonary circuit.
- 4. Impaired diffusion.
- 5. Impairment of oxygen transport (anemia, shock).
- 6. Problems of tissue utilization (cyanide poisoning, hyperthermia, etc.).

The treatment of most of these conditions is obvious. The obstructed airway must be unobstructed. Positive pressure oxygenation may help overcome some obstructions, but this is not considered to be assisted or controlled respiration in the usual sense. A tension pneumothorax can be converted to an open pneumothorax, and then controlled respiration is indicated. Controlled respiration may improve the blood flow by opening atelectatic areas of the lung. Better oxygenation secondary to augmented respiration may benefit the patient in shock. All of these measures, however, are secondary, not primary treatment.

Conditions in which augmented respiration is mandatary as the primary treatment are as follows:

- 1. Pharmacologic depression of respiration
 - a. With all general anesthetics
 - b. With all muscle relaxant drugs
 - c. Barbiturate and narcotic intoxication
- 2. Neurogenic depression of respiration
 - a. Ascending spinal cord disease (poliomyelitis)
 - b. Damage to respiratory center (brain tumor)
- 3. Muscular distrophies (myasthenia gravis)
- 4. Physiologic depression (CO₂ narcosis)
- 5. Some mechanical disruption of the lung-thorax system
 - a. Open chest (surgery or trauma)
 - b. Flail chest (crush injuries)

When should respiration be assisted and when controlled? This is a difficult question and requires some judgment and assessment of technique of the operator or machine. If it is believed that the patient's respiratory drive is adequate to maintain a reasonable

respiratory rate, and if the tidal volume can be augmented sufficiently to obtain the objectives outlined above, then there may be some advantage in "keeping the patient breathing." If both hands are needed momentarily for other tasks, if the endotracheal tube has to be disconnected for positioning in the cerebellar frame, if the patient is being anesthetized with a face mask and one is concerned about pumping air into the stomach, then assisted respiration may be preferred over controlled. One should never, however, try to "keep the patient breathing" at the expense of inadequate alveolar ventilation.

There are at least two situations in which it is probably wise to retain some degree of spontaneous respiration. One is during surgery of the posterior fossa of the skull or cervical region or both, where respiration is necessary as a guide to trauma of these vital areas as the surgeon proceeds. (Extirpation of the respiratory center is undesirable!) The other condition is where the anesthesiologist has no control over the airway, such as during tonsillectomy or bronchoscopy, where only an insufflation technique is used.

Technique

There are seven basic parameters that determine the external mechanics of breathing. The interplay of these values with the internal mechanics, such as compliance, will determine such things as the ventilation and circulation of the patient.

- 1. Respiratory rate.
- 2. Maximum inspiratory pressure.
- 3. Maximum expiratory pressure.
- 4. Other pressures.
- 5. Inspiratory time.
- 6. Expiratory time.
- 7. Expiratory pause.

The alveolar ventilation will depend upon the respiratory rate, dead space, and tidal volume, the latter determined by the foregoing pressures and phasings. It can be seen that beyond a certain point an increase in alveolar ventilation will not appreciably raise the arterial pO₂, but the arterial pCO₂ will continue to decrease for quite a while. Whether the extremes of a low pCO₂ are beneficial or harmful are beyond the scope of this discussion.

It should be obvious that the less work required to obtain the desired ventilation, the better. For example, the maximum inspiratory pressure should be just enough to raise the chest adequately. More pressure than this will have many deleterious effects, such as an increase in the respiratory dead space and a decrease in the pulmonary blood flow. The same is true for a negative expiratory pressure, which may augment ventilation by extracting more air from the lungs and thereby allowing a subsequently larger inspiration, and may increase pulmonary blood flow by drawing blood into the chest. An excessive negative pressure, however, may cause atelectasis, pulmonary edema, or air embolism.

The inspiratory and expiratory periods also have optimal limits. Periods that are too short may obstruct some air passages and cause unequal distribution to different segments of the lung; and those that are too long will cause cardiovascular impairment.

Some believe that the duration of inspir-

ation is very important, and certain respirators are equipped with a variable control for this phase. Theoretically any variation of the above parameters could be built into a respirator, and any except perhaps a negative pressure during expiration or the expiratory pause can be varied by "hand bagging." For most patients, however, a simple 1:1:1 phase with enough positive pressure to raise the chest wall (400-800 cc in the average adult) and a rate of 20 to 24 per minute will suffice.

If controlled respiration is used, rhythmicity is extremely important and should not be left to chance. It should be checked frequently with a second-hand watch, while one observes the chest and listens to the breathing tubes. Asthmatic and emphysematous patients will require different phasing (1:3:1 or 1:4:1 or more) and sometimes a high positive pressure for inflation. there is any decrease in cardiac output as suggested by a decrease in blood pressure or other signs, always suspect too great an inspiratory positive pressure, too long an inspiration, too short an expiratory pause, or too much positive pressure during expiration or pause.

The Basis of Safe Obstetric Anesthesia

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Safe anesthesia for obstetrics actually has the same basis as any other anesthesia—that is, the logical application of basic knowledge of physiology, anatomy, and pharmacology.

Normal Physiologic Changes in Pregnancy

Several physiologic changes occur during pregnancy. Some of those seen at term are as follows:

Changes in blood volume

Alterations in blood volume are probably the most significant changes encountered.

At term, total blood volume is increased 30% and plasma volume 40%, while the red cell mass is increased only 6%. There is, therefore, a pseudo or physiologic anemia. True anemia does occur, especially in the last trimester of pregnancy, when the supply of iron is less than demand. Since the uterus will contain 17% of the total blood volume, the circulating volume is not greatly increased. A false sense of security must be avoided here, and excessive blood loss should be replaced. The hemodilution has led to a 12% reduction in blood viscosity. The concentration of plasma protein is diminished; that is, the plasma volume has increased more than the protein volume. protein has actually increased 18%, with the

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albumin fraction decreasing, globulin remaining unchanged, and fibrinogen increasing both actually and relatively to a level 40% higher at term than normal.

Cardiac and circulatory changes

The cardiac and circulatory changes are marked. Cardiac output has risen 30% by the thirty-sixth to the thirty-eighth week, then progressively falls to about normal at term. Total peripheral resistance is lowered, and with the reduction in blood viscosity. flow is markedly enhanced. Total oxygen consumption is up 10%. Venous pressure in the arm remains normal; in the leg, however, it rises and frequently leads to ankle edema. Before diuretics are given, this edema should be differentiated from that of fluid retention or fluid and electrolyte imbalance may result. The heart is enlarged and the basal rate is up. Premature contractions are frequent, and all types of arrhythmias may occur. Systolic blood pressure should be normal; however, diastolic pressure is reduced.

Respiratory changes

Changes in the respiratory system have kept pace with the other changes. Vital capacity is normal or increased, and pulmonary ventilation is more than normal. Although the diaphragm is pushed up by the increasing uterine mass, the transverse and anteroposterior diameters are increased and breathing changes from abdominal to thoracic. The tidal volume is increased 20% and the respiratory rate 20%. The increased pulmonary ventilation and cardiac output enhance induction with inhalation anesthesia; and this acceleration, plus that produced by pain and apprehension, may result in a more rapid induction than desired. Pulmonary resistance is reduced by the relaxation of smooth muscle; however, there is more blood in the pulmonaryvascular bed, as evidenced by increased vascular markings on x-ray. There is engorgement of the mucosa of the nasopharynx and tracheobronchial tree, including the arytenoid area and false cords. Gentleness in applying endotracheal techniques is especially important now. There is incipient pulmonary edema

that overhydration or respiratory obstruction may convert to frank edema.

Other changes

Metabolism has increased 14%, and the increased peripheral blood flow helps dissipate the heat. Water and salt are retained in all compartments by action of the steroid sex hormones, but are lost rapidly at termination of pregnancy; this is possibly an important factor in the production of headache after lumbar puncture.

These normal physiologic changes must be considered by all who render prenatal care, or we will find ourselves trying to reverse normal changes to the detriment of the patient.

Placental Transfer of Drugs

Placental transfer of drugs deserves some thought. Essentially, every drug can cross the placental barrier, but the degree of permeability varies. As a barrier the placenta is similar and analogous to the "blood-brain barrier." Apparently of prime importance is the degree of ionization and livid solubility of the various drugs. The muscle relaxants, with the exception of gallamine, for all practical purposes do not cross. Succinylcholine may cross if administered in large doses, but the fetus is apparently not affected by the concentrations usually used. Curare given in normal clinical doses probably does not cross.

The placental site is actually an arteriovenous shunt, and this explains the mechanism of the cardiac and circulatory changes. As with any shunt we see (1) increased blood volume, (2) increased heart rate, (3) increased cardiac output, (4) increased oxygen consumption, and (5) decreased blood pressure with increased pulse pressure.

Anatomic Considerations: Conduction Anesthesia

There are some anatomic considerations. The vena cava, lying on the right side, is frequently compressed by the uterus, leading to the "supine hypotensive syndrome." This important cause of hypotension is relieved by the lateral position or uterine displacement to the left, making the use of

vasopressors unnecessary in 90% of the cases. Also, the marked increase in pelvic venous pressure may be a cause or factor in placental abruption.

The innervation of the uterus and birth canal makes an ideal situation for conduction anesthesia. Most of the motor fibers are via the sympathetic outflow system from dorsal segments 6 through 10. Sensory innervation is quite another matter. Most pain in the first stage of labor is conveyed over the sympathetic sensory fibers to thoracic segments 11 and 12. Second-stage pain involves these plus the second, third, and fourth sacral segments. Thus, blocks of thoracic 11 and 12 and sacral 2, 3 and 4 segments will provide complete relief of pain without interfering with the progress of labor.

Certain segments provide optimum sites for interruption of the sensory pathways:

- 1. Subarachnoid block is probably the easiest to perform, but requires experienced and careful management.
- 2. Caudal block, also easily mastered but difficult to accomplish in at least 10% of cases because of anatomic variations, requires constant attendance.
- 3. Lumbar epidural block is an excellent, sophisticated technique for experts only.
- 4. Upper lumbar sympathetic block is probably not very useful clinically because it is a major block, somewhat difficult to perform, and provides no relief of second-stage pain.
- 5. Thoracic somatic paravertebral blocks (T 11 and 12) also are of limited usefulness.
- 6. Paracervical or uterosacral block is easily done but is said to decrease uterine blood flow, with deleterious effects on the fetus. Moreover, a high incidence of convulsions has been reported.
- 7. Pudendal nerve block is easily learned and is excellent for spontaneous normal deliveries and probably the safest and most useful procedure that may be used by the generalist for relief of pain during the second stage.

Supplemental analgesia—for example, nitrous oxide-oxygen—is needed to obtund the

pain of contractions. True saddle block, limited to the sacral segments, shares this limitation; therefore, a modified saddle anesthesia extending to the tenth thoracic segment, is more useful clinically, whether achieved with subarachnoid, lumbar epidural, or caudal blocks.

Although an intact intrinsic nerve supply is not a prerequisite for normal labor, as shown by experience with paraplegics, levels of spinal anesthesia above the seventh and sixth thoracic segments will usually stop or delay the onset of labor. Since the nerve fibers involved are sympathetic (small c fibers), block of these fibers in the subarachnoid space may be more extensive than block of somatic sensory fibers as determined by pinprick.

Small doses of spinal anesthetic agents lead to considerably higher levels of anesthesia than do the same doses in non-pregnant women, and failure to recognize this fact explains why overdosage of spinal anesthetic agents is the second most frequent cause of maternal anesthetic deaths. A theoretic explanation for higher spinal levels during pregnancy is that pregnant women have a decreased volume of cerebral spinal fluid due to venous congestion in the epidural and subarachnoid spaces.

Hypotension

The effect of spinal anesthesia on the blood pressure is greater during pregnancy than in the non-pregnant state. Studies with continuous differential total sympathetic block showed that normotensive non-pregnant women experienced a 7% drop in pressure, while normotensive pregnant women at term showed a 43% drop in systolic pressure and a 53% drop in diastolic pressure. In the same women 48 hours later the pressures were only 12% below normal. Why?

One-sixth of the total blood volume is in the uterus at term; therefore, a proportionately greater percentage of the circulating volume will be trapped peripherally with use of sympathetic block. This tremendous venous pooling decreases cardiac output and the blood pressure. The toxemic patient shows a greater absolute decrease, but the percentage is less. The importance of the decreased blood pressure is that during contractions, especially with bearing down, intrauterine pressure may exceed both maternal and fetal arterial blood pressures; thus they will be inadequate to return blood to the placenta, and placental gas exchange may cease.

Treatment of hypotension is precarious. Vasopressors may well not be indicated, since the uterine artery has been shown to be especially reactive and their use may actually further decrease uterine and placental blood flow. Also, if they are combined with ergot alkaloids there may be synergistic action with a marked rise in blood pressure. The best treatment is probably (1) left uterine displacement to eliminate the "supine hypotension syndrome"; (2) elevation of the legs, and (3) rapid infusion of 500 ml of 5% dextrose in water. Pure oxygen should of course be administered while these measures are being carried out. These maneuvers will eliminate the necessity of vasopressors in 90% or more of instances.

Before leaving the subject of spinal anesthesia, I would warn against use of the reverse Trendelenburg position in the treatment of an overly high level, because the resultant decrease in venous return, and therefore cardiac output, is an invitation to cardiac arrest. One condition in which spinal or other conduction anesthesia is preferable from the point of view of infant safety is prematurity.

Inhalation Anesthesia and Analgesia

General anesthesia should have no place in the management of normal vaginal delivery, but when properly administered, of course, is useful in operative obstetrics. Inhalation analgesia, however, has much to offer and is widely used for relief of both first-stage and second-stage pain. Trichlor-ethylene is well known as an analgesic for labor. Nitrous oxide-oxygen supplementation of pudendal block is probably the safest effective method of management of normal vaginal delivery. We have found very small amounts (0.2% to 0.5%) of methoxyflurane (Penthrane) with oxygen to be equally if not more effective.

For full general anesthesia, the overall flexibility of cyclopropane ensures this drug a place in obstetric anesthesia. Its explosiveness and its demand for skillful handling limit its use. Ether and halothane are both excellent uterine relaxants, and their obstetric usefulness lies in the realm of intrauterine manipulations. Every anesthetic agent has been used, but they all share the disadvantage of the danger of vomiting and aspiration, which is the foremost cause of maternal anesthetic death.

Conclusion

The basis of safe obstetric anesthesia is, then, a logical rather than a routine approach to the problem. The type of anesthesia alone cannot compensate for poor obstetric and anesthetic management.

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I am sorry, indeed, to observe that the power of the magistrate is seldom exerted in this country for the preservation of health... Many things highly injurious to the public health are daily practiced with impunity, while others, absolutely necessary for its preservation, are entirely neglected—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Philadelphia, Richard Folwell, 1799, p 11.

Closure of Tympanic Perforations

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The first successful closure of a tympanic perforation was reported by Berthold in 1878. Other otologic surgeons who tried this operation failed, however, and the practice of tympanoplasty was soon abandoned. During the early 1900's surgery in chronic ear disease was often considered a life-saving measure; and the principle of exteriorization of disease was adopted by most otologic sur-The preservation of hearing was possible at times, but little attention was given to its restoration. Since the results reported by Wullstein and Zollnar, however, tympanoplastic techniques have been enthusiastically adopted and modified by otologists all over the world.

The eradication of infection, the restoration of function, the preservation of the ear canal, and the reconstruction of the tympanic membrane are the four objectives the otologic surgeon must master if he is to be successful. Difficult as it may be in practice to separate these four objectives, this discussion will be limited to the last—namely, reconstruction of the tympanic membrane.

Development of Techniques

Methods of tympanic membrane reconstruction have been greatly improved since the original work of Wullstein and Zollnar. The once popular split- and full-thickness skin grafts from the arm, leg, and postauricular areas are largely of historical interest, as they often fared poorly as tympanic grafts. These tissues were difficult to handle; the reconstructed membranes were thick and cumbersome; and unsightly scarring of the donor area was undesirable. The lack of epithelial migration and the frequent accumulation of debris necessitated frequent cleansing of the ear canal and tympanic surface. Myringotomies frequently did not heal; and if a hair follicle or gland lay in

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the line of the incision, a cholesteatoma or cyst often developed.

The use of split-thickness skin frequently resulted in partial necrosis of the graft within three months following surgery. These perforations, which almost never closed spontaneously, were believed to be due to an inadequate blood supply caused by the absence of the subdermal vascular plexus. Other cases may have failed because hair follicles or glands were cut off at the time the graft was obtained, producing a microscopic, squamous, epithelial-lined perforation.

Full-thickness grafts fared better, being subject to fewer perforations because of a more adequate blood supply. Perforations, though appearing later, usually resulted from a circumscribed cellulitis or an epithelial inclusion cyst.

The introduction of fat, fascia, periosteum, and vein represented a forward step in tympanic grafting. The use of these materials resulted in a thin layer of fibrous tissue covered on its under surface by mucous membrane and on its external surface by thin, squamous epithelium, a structure resembling the normal tympanic membrane. These tissues are especially suitable, as they have a low metabolic rate and can survive with relatively slight changes in structure until incorporated into the newly formed membrane. They also have a common advantage over skin in that they can be applied to either the outside or the inside of the drum remnant, as conditions indicate; and, if necessary, the graft can be extended up under the canal skin itself for a broader bed.

Fat, which is readily available in the ear lobe, has proved to be a satisfactory tissue for the repair of small perforations.

Fascial and periosteal grafts are easily obtainable in sizes large enough for closure of total tympanic perforations. Myringotomies and spontaneous perforations in tym-

panic membranes reconstructed from these tissues almost invariably close. Formation of an epithelial layer over the fascia and periosteum is sometimes delayed, however, by the formation of polypoid granulations on their surfaces; but, following removal of this tissue, coverage is almost always satisfactory. Repair with these tissues frequently results in a thickened tympanic membrane and slight impairment of middle ear function as compared to other methods.

Vein grafts were introduced into otologic surgery in 1957, when Shea reported using them to cover the oval window during stapedectomy procedures and to repair lacerations of the tympanic membrane. In 1960 Tabb reported favorably on their use in closing central perforations; and, in 1963, Austin and Shea reported their experience with vein in the repair of all types of tympanic perforations.

When healed, vein grafts closely resemble the normal eardrum. If they are positioned with the intimal surface facing the medial wall of the middle ear, adhesions are less likely to occur than with other grafts. Also the tunica adventitia is rough, and its sticky surface clings readily to the Though it blends in with recipient bed. adjacent tissues, it retains many of its features and shows an increase in elastic tissue, increasing the chances of good physiologic repair. It has a high resistance to infection, and myringotomies or spontaneous perforations heal satisfactorily. In some instances, however, it may be difficult or impossible to find a vein of adequate caliber to bridge a large perforation. Though a one-piece graft is naturally to be preferred, this situation can be handled by overlapping pieces of vein or laying them side by side.

The use of external auditory canal skin was a comparable step in the progress of tympanoplasty, as it is an excellent material for tympanic grafting. Like the epithelial layer of the tympanic membrane, this skin lacks rete pegs, hair follicles, and sebaceous glands. It is thin and easily obtained with the underlying periosteum. There is little danger of cyst formation if the periosteal bed is completely denuded, in view of the

fact that there are no epithelial elements in this tissue. There is also a low incidence of dermatitis; and there is a continual migration of epithelium from the center to the periphery, which disposes of debris deposited on the drum surface. This tissue is also native to the area. Myringotomies and spontaneous perforations heal in almost every instance.

Many other materials have been used in tympanic grafting, but they have achieved little popularity.

Preoperative Evalution of Patients

A thorough preoperative examination of the patient with chronic ear disease is necessary for the proper selection of candidates for the repair of tympanic perforations.

The ear must be cleared of any focus of infection. Where indicated, culture and sensitivity tests are obtained; and the patient is started on specific local antibiotics. Gentian violet, argyrol, or Burow's solution may be used locally when tests reveal the organisms insensitive to specific antibiotics. Secretions must be aspirated, and inaccessible areas must be irrigated with a cannula at frequent intervals. Except in the presence of a cholesteatoma or osteitis, conservative methods of treatment usually produce a dry ear. If mastoid surgery is necessary for the eradication of infection, it should be as conservative as possible, especially with regard to preservation of the posterior ear canal wall, tympanic annulus, mucous membrane of the middle ear, and Eustachian To guard against latent tube function. infection, tympanic repair should be postponed until the ear has been perfectly dry for at least thirty days.

An audiologic evaluation must always be performed prior to surgical repair of the tympanic membrane. An adequate cochlear reserve, which may be measured by air and bone conduction thresholds, is necessary for the successful restoration of practical hearing. The patient's ability to discriminate sounds is also of vital importance and may be evaluated with phonetically balanced words. Either poor cochlear function or a low discrimination score may be a contraindication for tympanic repair in certain

cases. In the case of bilateral involvement, attention should be called to the dangers inherent in operating on the better ear. Also, since a severe cochlear loss may result from a tympanoplastic procedure, extreme caution should be exercised when the involved ear is the only remaining source of hearing. In this type of case, repair of the simple perforation may be indicated when done under ideal conditions; but a more advanced type of procedure may be hazardous.

The restoration and maintenance of Eustachian tube function is of vital importance in the repair of tympanic perforations. In some instances, tubal obstruction may be due to granulation tissue, edema, or a cholesteatoma in the middle ear space, necessitating intensive localized treatment for the restoration of function. In other cases, the eradication of nasal, nasopharyngeal, and sinus infections, as well as the control of allergic conditions affecting the upper respiratory tract, may be indicated.

Though patency of the Eustachian tube can be ascertained by politerization, the Valsalva maneuver, catheterization with inflation. clearance studies and radiopaque dves, tubal function cannot be accurately evaluated with present methods. The surgeon, therefore, must assume that a patent Eustachian tube is a normally functioning one. And if the tube is non-patent, or if the patency cannot be reestablished, reconstruction of the tympanic membrance should not be attempted.

Technique

All surgical procedures are performed under general intratracheal anesthesia. Hemostasis is achieved by the injection of 1 ml of 2% xylocaine with a 1:50,000 concentration of adrenalin into the skin of the four quadrants of the ear canal at the osteocartilaginous junction. An additional 3 to 5 ml is injected into the postauricular sulcus.

A modified endaural incision is made to the depth of the temporalis fascia and extended down to a point 2 mm from the junction of the eardrum remnant and skin of the ear canal, at a point just posterior to the short process of the malleus. A second incision is then made across the posterior wall of the canal 1 to 2 mm medial to the osteocartilaginous junction and parallel to the tympanic annulus. It extends to the junction formed by the floor and the posterior wall of the ear canal. A third incision is made from the inferior end of the second incision, laterally, to the level of the conchal cartilage. The outlying skin flap is elevated laterally with the underlying periosteum; and a self-retaining retractor is inserted (Fig. 1), leaving both hands free for instrumentation.

In many cases, it is advisable to make a postauricular incision in addition to the endaural incision, to afford better visibility of the tympanic remnants. This is accomplished by making an incision in the postauricular sulcus through the skin and subcutaneous tissues. The incision is then carried parallel to the surface of the temporalis muscle until the dissection enters the previously made endaural incision. The skin flap, which was elevated at the time the endaural incision was made, is retracted with a piece of umbilical cord tape; and a postauricular retractor is inserted (Fig. 2).

The perforation is carefully examined as to size, shape, and irregularity or thickening of its margins. All areas of tympanosclerotic plaque formation in the drum remnant should be noted, and large plaques should be excised. For all perforations involving two-thirds or less of the tympanic membrane, the graft bed is prepared by removing all squamous epithelium from the rim of the perforation with a tympanoplasty knife and cup forceps.

The remaining posterior canal wall skin is elevated medially down to the tympanic annulus, which is removed from its sulcus; and the skin flap and drum remnant are folded anteriorally (Fig. 3). A careful evaluation of the tympanic cavity must be undertaken. This may necessitate removing a portion of the posterosuperior canal wall bone, which can be accomplished with a microcurette. The chorda tympani nerve should not be sacrificed during this procedure unless absolutely necessary. The ossi-

cular chain should be examined for freedom of movement and continuity. The oval and round window niches should be found free of disease. A meticulous search should be made for the presence of a cholesteatoma or epithelial remnants, and the condition of the tympanic cavity should be noted. The undersurface of the margins of the perforation should be examined for the presence of epithelial growth, and the skin flap and drum remnant are then folded back into its normal position.

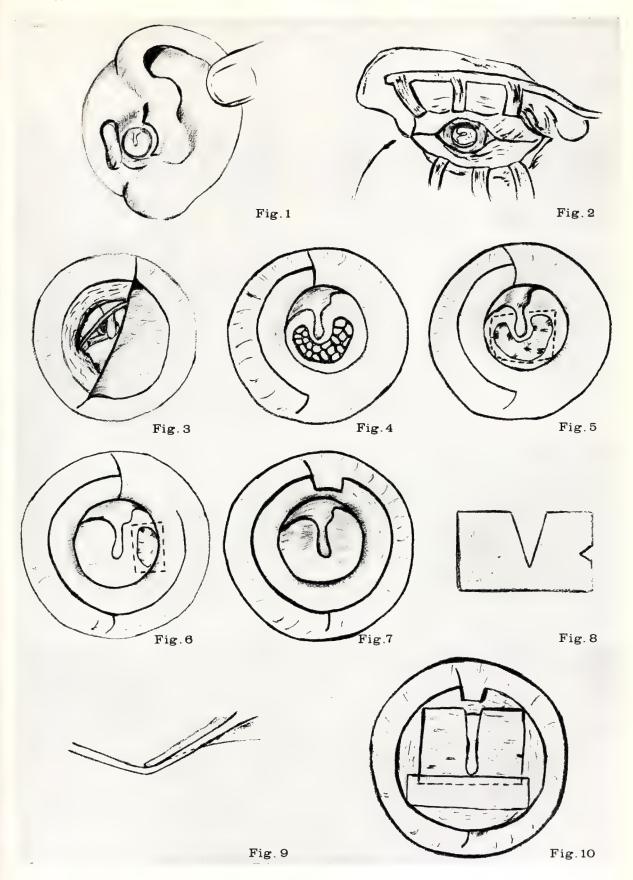
The perforation is measured with a fenestrometer, and an appropriately sized vein graft is cut with a Bard-Parker No. 11 blade to allow a 2 mm overlap on each margin. Gelfoam pledgets, soaked in antibiotic solution, are packed in the middle ear space to form a support for the vein graft (Fig. 4). The vein graft is placed over the perforation with its adventitial surface facing outward. The margins of the graft are then tucked under the margins of the tympanic remnant (Fig. 5). If the middle ear space is shallow, the graft may be placed on the outer surface of the drum remnant, provided all epithelium has been dissected from the area which will come to lie under the surface of the graft. In those cases with marginal perforations, one edge of the graft may be placed on the adjacent canal wall and tucked under the ear canal skin. This may be accomplished by extending the circumferential portion of the endaural incision along the osteocartilaginous junction, so that the ear canal skin can be elevated from the underlying bone for proper placement of the graft (Fig. 6). Frequently this will also decrease the size of the perforation by lessening the tension on the tympanic remnants. In those cases involving a tortuous ear canal and an anterior perforation, it may be necessary to remove a portion of the bone from the anterior wall with a curette in order to observe fully the anterior margin of the perforation and the tympanic remnant.

In those cases of three-fourths to total perforation, a combination of ear canal skin and vein are used as a graft.

The ear canal skin is first removed by

extending the circumferential portion of the endaural incision along the osteocartilaginous junction to a point at the junction of the anterior and superior canal walls. A radial incision is extended from this point, medially, to within 2 mm of the margin of the tympanic membrane and just anterior to the malleus. The end of this incision is connected to the end of the radial portion of the previously made endaural incision, along the roof of the ear canal. The skin is elevated with a duckbill elevator down to the level of the tympanic annulus. The epithelial layer is then dissected from the surface of the drum remnants (Fig. 7). After

- Fig. 1. Skin flap incision. Skin and periosteum should be elevated laterally and a self-retaining retractor is inserted for full visualization of the operative field.
- Fig. 2. Postauricular incision with postaural retractor in place to improve exposure of tympanic cavity.
- Fig. 3. Partial view of tympanic cavity after removal of a portion of the posterosuperior bony canal wall. The corda tympani nerve, stapes, stapedius tendon, long process of the incus, and round window can be seen.
- Fig. 4. Gelfoam pledgets placed in tympanic cavity to form a support for the vein graft.
- Fig. 5. Vein graft in position with adventitial surface facing outward.
- Fig. 6. Marginal perforation with vein graft in position. The anterior portion of the graft is placed on the bony surface of the ear canal and tucked under the ear canal skin.
- Fig. 7. Incisions with revoval of all epithelium for the repair of three-fourths to total perforations.
- Fig. 8. Shape of vein graft to be used in the repair of large perforations.
- Fig. 9. Position of vein graft with tip of the deep V notch placed under the tip of the malleus.
- Fig. 10. Repair of total perforation showing vein and canal wall skin grafts in proper position.



removing all epithelial remnants, the perforation is measured.

The vein graft is then cut to the specified size, allowing for a 3 mm overlap on the posterior, superior, and anterior canal walls. A large V notch is cut in the superior margin of the vein, and a smaller notch is cut in its anterior margin (Fig. 8). The vein graft, with its adventitial surface facing outward, is placed over the middle ear space on a layer of gelfoam. The tip of the deep V notch is placed under the tip of the malleus, and its margins are placed along the long process of the malleus. This position maintains the normal conical shape of the new ear drum (Fig. 9). The notch in the anterior margin of the graft prevents lipping when placed on the anterior canal wall surface. The canal wall skin is trimmed and its thinnest portion is placed over the tympanic cavity, allowing for adequate overlapping on the adventitial surface of the vein graft, as well as on the anterior and inferior canal walls. Its thicker portion is placed on the posterior canal wall (Fig. 10).

In each case, a layer of gelfoam is placed over the grafted area; and rayon strips with cotton balls are used in packing the ear canal. The patient is maintained on an appropriate antibiotic for 24 hours preoperatively and seven days postoperatively. A mastoid dressing is applied for 48 hours. All packing may be removed from the seventh to the tenth postoperative day. If ear canal skin has been used in the repair of the tympanic perforation, secondary grafting of the canal should be done on the twelfth to the fourteenth postoperative day, using small Thiersch grafts from the under surface of the upper arm.

Early failures are usually due to faulty positioning of the graft, inadequate control of the bleeding, improper packing, or failure to completely eradicate infection.

Conclusion

If patients are carefully evaluated and treated with judicious and skillfully applied techniques, a high degree of success can be achieved in the repair of the tympanic perforations.

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As matters stand at present, it is easier to cheat a man out of his life than of a shilling, and almost impossible to either detect or punish the offender.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 16.

The Metastasis of a Surgeon

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When I was asked to speak on the philosophic aspects of surgery as opposed to its scientific and technical aspects, it occurred to me that in the past quarter of a century the surgeon has undergone a remarkable transformation, and that I personally had been caught up in it. It has been an insidious transformation, and I was not fully aware of it until I began to reflect seriously on these changes. A Greek philosopher has noted that "Times change and we change with them," but even better, an old Chinese proverb tells us that "The only thing constant in life is change."

The surgeon perhaps has been molded by his environment and demands to a greater extent than have most professional men. I will not attempt to trace this metagenesis from its ancient beginnings, but rather will confine my observations to the past one or two generations of which I have been a part and have had the good fortune to observe, for my own analysis and evaluation, these remarkable changes.

In our own time and experience the surgeon's basic art has changed from supportive and eradicative surgery to complex techniques, physiochemical readjustments, and total replacement surgery. Two generations ago he stood alone—a rugged individualist, having total and absolute responsibility for the patient on the operating table. He had few hands to help him. He had no physiologist in the person of an anesthesiologist at the head of the table; he had no complicated machines to support his procedures; and, above all, he depended on his own intuition and senses to alert him to all the physiologic processes of the patient under his knife.

Time and speed were all-important then, because he could not depend on prolonged anesthesia for the relaxation he needed so badly in order to practice good surgery. In addition, his anesthetic agent was toxic and anoxic in the concentrations required for

adequate surgical anesthesia and, if prolonged, caused the patient's condition to deteriorate while he lay on the table.

Moreover, the surgeon lacked the equipment and means of supporting the vital physiologic processes over long periods and had therefore to hurry through his operation. The evolution of the anesthesiologist into the physiologist of the team has made a vast difference in the surgeon's responsibility and methods during complicated procedures. Likewise, the specter of infections hovered heavily over every operation and the need for wide drainage was paramount. Infection and its associated complications were prominent factors in restricting all surgical procedures, both as to the time involved as well as the dangers of primary definitive single-stage procedures, and led in many fields to the development of multistage operations for greater safety and reduced mortality.

In contrast, the surgeon today—in many instances the same surgeon that I have just described but representing a transmutation—has become a highly skilled specialist surrounded and supported by teams of highly skilled technicians, machines, and complex instruments which are gradually obscuring his identity. As a residual of the immediate past, however, he must still exercise great judgment and skill; he still must use the scalpel and the hemostat and be dexterous with his square knots, although electrodissection and dessication, sewing machines, and staplers are eroding even these time-honored basics of his art.

So much has been discovered and applied to divert attention from the operative treatment and management of many diseases formerly treated entirely by surgery that it is now possible to get the impression that surgeons may become unnecessary in the not too distant future. Theoretically at least, the discovery of the exact etiology of a disease should shortly be followed by a specific medicinal cure, and eventually by its pre-

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vention. Therefore, when any disease that formerly was primarily managed surgically is brought under control by medical treatment or prophylaxis, the total volume of surgery is thereby reduced accordingly.

Some common examples of diseases in which surgical treatment has been virtually eliminated or at least greatly reduced are the many varieties of "surgical" infections that were so common and required so much time and surgical effort in the past. Among them were suppurative sinusitis, lung abscess, bronchiectasis, osteomyelitis, and tuberculosis. We remember vividly the multiple surgical procedures and long, complicated Dakin's type of dressings for chronic abscess and osteomyelitis. The advent of antibiotics has radically changed the management of all types of infection and particularly has eliminated many of the destructive and late stages of chronic infection in many organs and tissues of the body where staged surgery was then the only hope of a cure.

The prevention and control of serious complications and infections, on the other hand, opened up many new fields of complex surgery, especially neuro- and thoracic surgery. In spite of these new fields of surgical endeavor, however, the total volume of surgery has been reduced by the inroads of medical research and the discovery of other forms of effective treatment and prevention. The surgeon of tomorrow will still be busy with much more complex problems — long operations but perhaps fewer in number.

What will be the impact on surgery of the future when such large volume diseases as carcinoma, peptic ulcer, ulcerative colitis, goiter, calculus, acquired vascular disease, metabolic disease and have been eliminated from the realm of surgical treatment by discoveries of the exact causes and will be cured, or prevented, by medical measures? With the vast world-wide clinical research projects that are under way today, it is readily conceivable to me that, as time goes on, many more diseases will no longer require surgical treatment, and the surgeon

and his art will undergo further radical changes.

I am sure that the surgeon will still have much to do, particularly in the field of complex reconstructive and replacement surgery. However, the accomplishments of this present era are indeed fantastic, bordering on the miraculous—so much so that we must be extremely careful not to exaggerate, confuse, or misapply these amazing new concepts of treatment, to the detriment of the patient and to the detriment of those who are learning our art.

Certainly we must be very careful of what we call miracles in medicine, and of how we present them to our younger generation of doctors. We must avoid precipitously discarding well established and well proven surgical procedures for theoretical and untried procedures, drugs, and medical therapy. Certainly we as surgeons have observed the advantages, and at the same time some serious disadvantages of the recent advances in medical science. Consider steroids. for example. In critical surgical conditions such as the vastly devastating disease of acute hemorrhagic or necrotic pancreatis, steroids may well have an important place. But what surgeon has not been staggered by the crowning blow of a fatal hemorrhage or a perforation of a stress ulcer while the patient was receiving steroid treatment; or has not been called in consultation on a case of fulminating ulcerative colitis in a patient who is moribund, pulseless, and cushingoid from steroids, and asked to perform a miracle and a cure. These are a few outstanding examples of the case in point, but many other hazards are produced by common therapeutic regimens of which the surgeon must be aware and from which he must carefully shield his patient in order to avoid serious complications.

On the other hand, the surgeon today has fewer complications to deal with, again as the result of good anesthesia, antibiotics, and many supportive measures. A surgeon's skill and ability in the past were chiefly measured by his low mortality and good results; his skill today should be measured

not only by these criteria but also by the lowest possible morbidity. Minimal complications and morbidity are the direct result of meticulous attention to detail—perfect hemostasis, complete avoidance of tissue trauma, and above all, a technique that holds preservation of function foremost in the surgeon's mind.

For example, the stomach is a hardy organ which when used for intrathoracic displacement to bridge a resected section of esophagus can be carelessly handled and have most of its blood supply interrupted and still survive. Under these circumstances, however, its function will be impaired, a fact that has led to the substitution of other organs for this purpose, such as the jejunum or the colon. On the other

hand, if the stomach is not traumatized by instruments and traction during its mobil-zation and if a maximum blood supply is retained and meticulous hemostasis is achieved in the anastomosis, the stomach will function well in its new environment.

In many ways the surgeon's task in the future will be more complex, and it will be more difficult to maintain or reproduce complicated organ functions that he is attempting to reconstruct or replace. But, on the other hand, he will have much in the way of help from many quarters, and for certain, he will still have great work to do, and his art will continue to undergo amazing metastasis.

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Everybody's Hospital: A Brief History of the Central Carolina Convalescent Hospital

JOHN S. STEVENSON WINSTON-SALEM

The history of the Central Carolina Convalescent Hospital in Greensboro, North Carolina, is the story of the unselfish spirit of a community in a time of crisis. It is an epic in humanitarianism, one which reveals the willingness of people to put aside all differences and combine their resources and efforts to accomplish a seemingly impossible task. This is the story of how a community, faced with a disease which paralyzed not only the body but the community as a whole, licked polio.

During the spring of 1947 there was little concern about poliomyelitis in Guilford County. Greensboro and the surrounding areas had been relatively free of the disease since 1944, even though its paralyzing power had encircled the Tar Heel State. However, the summer and fall of that year produced a surprising number of new cases. No prior preparations had been made to establish an emergency center for the area. Consequently, when cases began to occur the patients were sent to hospitals throughout the state. When the toll reached 0.11% of the total population, which the National

Foundation for Infantile Paralysis considered sufficient to warrant establishment of facilities to treat polio patients, the people of Guilford County responded.²

Center Opens at Overseas Replacement Center

A polio center designed to treat convalescent patients was established under the auspices of the Wesley Long Hospital. About the last of October the Guilford County chapter of the National Foundation for Infantile Paralysis selected and secured a bleak frame building on the outskirts of Greensboro, at ORD (Overseas Replacement Depot). Volunteer workmen repaired, renovated, and equipped the building, using materials donated by local firms. It was rustic and rough, but cheerful and clean. The National Foundation supplied medical equipment, funds for patient care, and \$25,-000 for renovations. The hospital was the only one of its type organized and promoted by a local chapter of the National Foundation for Infantile Paralysis. its opening on November 13, all Guilford County patients were returned from other hospitals, and the facilities were made available to anyone who needed them.^{1,2}

In March of 1948 a confidential bulletin from the National Foundation chapter in New York to the Guilford County chapter warned that the incidence of polio in the area was acting dangerously. In an effort to "be prepared", the chapter alerted its own organization, lined up hospital space, and evaluated its facilities. It was decided that the new unit at ORD was adequate.

During the next month private physicians and public health officials were alerted and sent data. In May Dr. Philip S. Stimson, poliomyelitis specialist from New York's Knickerbocker Hospital, held a symposium for Greensboro doctors and warned them to "be ready." The number of cases reported was beginning to increase. In April Greensboro had three cases. In May there were more than 19 in the city and more than 29 in the county. During June the toll rose to 176, including five deaths. began to creep into the community. Parents started sending their children to visit relatives and friends in the North. Business slumped as salesmen and farmers avoided the city, and rumors spread that Greensboro residents would be barred from entering other states.

By early July preventive steps were being taken. Polio emergency teams were sent by the National Foundation to hold clinics and demonstrate, to doctors and nurses, the latest techniques of treating and combatting polio. Planes sprayed the streets with DDT. Doctors, physical therapists, and nurses were recruited to assist in the ORD Convalescent Hospital. The city's recreational facilities, playgrounds, and pools were closed July 12. A voluntary ban against admitting children under 16 years of age to movie theaters went into effect on the thirteenth. The YMCA pool was closed on the fourteenth. Visitors were forbidden in hospitals and Sunday schools were closed, with Bible lessons being taught by radio. 1,3

In spite of all these efforts, July and August saw Greensboro become the worst hit community in the nation, based on percentage of population. (Los Angeles County, California, and Harris County, Texas, reported more cases, but the proportion was not as great.) Local hospitals averaged nearly two deaths due to polio a week, about half of these involving Greensboro residents. By August 31 the county disease total had reached 205, with 101 patients coming from Greensboro.⁴

However, with the coming of fall and cooler weather the incidence began to level off, and then dropped sharply. During August Greensboro had 19 new cases and 10 in September. There were still enough to delay opening of city schools until September 20, but by the 13th, Dr. Frank K. Harder, head of the County Health Department, had declared the epidemic over.^{1,3,5}

Forewarned, Forearmed

If the Greensboro-Guilford County community had not had the forewarnings provided by the data of the National Foundation for Infantile Paralysis, or the excellent leadership of the local chapter, it would never have been prepared to meet the needs posed not only by the local residents, but also by those of the 16-county area which it was designated to serve. By May of 1948 it was evident to the leaders of the local chapter that the existing facilities at ORD were inadequate. They were already filling up, and it was apparent that the situation was going to get worse. Norris Hadaway, chairman of the chapter, began hunting for new facilities. He had earlier contacted H. L. Coble, a local contractor, who had estimated that a semipermanent structure could be built in 30 days, but it was apparent that the epidemic would not wait that

In mid-June the Greensboro City Council met to consider the possibilities of securing an existing structure which could be immediately converted into an emergency convalecent hospital. After inspection, the Council decided on the North Green Street headquarters of the North Carolina Employment Service, known as the old Record Building. This property was donated, and in 48 hours, volunteer workmen were stripping away office furnishings, erecting partitions, and

bringing in medical equipment. On July 1, sixty youngsters were transferred from ORD to the new uptown polio unit, which was operated by Wesley Long Hospital. Its 68 beds were hastily filled. The old hospital was converted into an isolation unit for the acutely ill, and these two facilities became the central medical center for sixteen counties.^{1,3,7}

As soon as the new facilities were opened they were filled and overflowing. It was obvious that a more adequate hospital was urgently needed. Patients stricken in Greensboro were still having to undergo convalescence as far away as Camp Sutton in Monroe.

Campaign for New Hospital Begins

On June 21 the Greensboro Chamber of Commerce sponsored a meeting at which the new hospital was proposed. The old Coble figures were revised, and it was estimated that a semi-permanent, barracks-like hospital could be built for about \$60,000 cash, in 30 days. There were two major problems: how to operate it and how to raise the money. The original plan of operation called for a ten-county system of control, but Wesley Long could not run it under such a system. This plan was abandoned for that of a private corporation, operated at first by Wesley Long as an assisting unit. Central Carolina Convalescent Hospital became a corporation under North Carolina laws, and C. M. Vanstory became the first president of its board of trustees. It was decided that the hospital would be financed by the public at large and would be "everybody's hospital.1,3,7

Fund Drive

Carl Jeffress, business manager of the *Greensboro Daily News* and *Greensboro Record*, offered the help of the two newspapers in the fund appeal. He was appointed chairman of the drive, and in this capacity enlisted the aid of the radio stations as well as other newspapers. On the Fourth of July the Greensboro News Company opened a state-wide appeal. Other independent appeals sprang up spontaneously over the state. Jeffress and his committee had ex-

pected a slow, uphill battle, but the response to the drive was overwhelming.^{1,3}

The small Whitsett and Gibsonville communities "jumped the gun," and in the 24 hours of July 3 raised \$1,225.59.

Bob Jones, of Station WBIG, started his own polio fund drive. On his early morning show he announced, "I'm going to beat this gong, and keep beating it until you people come across with money for the new hospital. Now, who'll give \$50 . . . \$100 . . . \$200?"³ His switchboard was flooded with calls. In the next few weeks he raised more than \$51,000.^{1,3}

Greensboro Elks, Shriners, Optimists and firemen formed the K. O. Polio Club and waged a full-scale campaign throughout the Piedmont. They organized square dances, baseball games, and a half-mile parade that all brought in \$75,989.83.1

The High Point Jaycees and Station WHPE opened a drive and Polio Bridge that brought \$10,000 in the first 48 hours, and a total of \$53,130.63. Randolph County contributed \$10,731.03, and the Greensboro News Company topped the record with \$119,915.42.1

At the end of the first two weeks of the drive, more than \$100,000 of this money had been collected, and there was no let-up in sight. In view of this response, officials dropped plans for a temporary building and decided on a permanent 134-bed modern hospital, to be the second largest polio hospital Ground had already been in the world. broken on July 8, by four convalescent polio patients, on land leased from the county. Due to the permanent nature of the structure now being planned, on July 26 the county donated this land to the hospital, with the single restriction that it should never be used for commercial purposes.6

A new goal of \$175,000 was set for this new project, but it was almost immediately topped. Money poured in from all over the Piedmont and the state. Cab drivers and waitresses donated a day's fares and tips. Community sings, auctions and rallies, with the ever-present Oriental Shrine Band, turned the fund drive into an avalanche that could not be stopped.

By July 29 more than \$200,000 had been collected. An August 15 deadline on the appeal was made by Norris Hadaway, who realized that it was draining the countryside and hurting the chances of future drives. By September 2 the total of the drive stood at \$311,363.80.1

As soon as money started to come in, preliminary plans were drafted by architects Edward Loenstein and Charles C. Hartman, who donated their services, valued at over \$24,000. From then until the completion of the hospital, they worked 12 hours a day, to keep up with the work and revisions made as funds increased.¹

Procurement Problems Met

The cane field on East Bessemer and Huffine Mille Road was cleared, but postwar shortage of men and materials posed grim problems, when time was of utmost importance. The man appointed to meet these problems was John R. Foster, co-ordinator and head of a close-knit procurement committee, who managed to perform small miracles with men and supplies. When there was no labor, his SOS across North Carolina brought dozens of workmen to the hospital site. When there were no materials, his calls to America's biggest industrialists brought sympathetic aid every time. He and his committee members pulled all available strings to get supplies and transportation for them.

When badly needed steel sashes were located in Glendale, Long Island, a telephone call brought them South instead of to their original destination, a New York apartment house.

When there was a severe shortage of cement, Foster phoned an influential Washington friend who, in turn, phoned a more influential liquor dealer. A carload of cement was sent immediately.

Blue Bell trucks were used to transport water heaters from a Terre Haute, Indiana, factory, hours before a strike closed it down. Political strings were pulled to transfer a boiler and 15 fans from the state hospital at Camp Butner.

The most dramatic procurement story was the transport of a rush order of 13,700 pounds of heating equipment from La Cross, Wisconsin. Normal procedures would have taken 30 days. Air transport was too expensive, and there were no regular flights between the two cities. Then Judge E. Earle Rives wired an old friend, Secretary of the Army Kenneth Royall, who contacted the Air Force Chief of Staff. He signed an order for two C-82 "Flying Boxcars" to fly a special mercy mission. Shriners met the planes at the Greensboro Airport and rushed the equipment to the hospital, where workmen were waiting to install it.

Manpower

The call for labor produced the most unselfish community co-operation of the entire project. Volunteer workmen came from all over the Piedmont and state. One steamfitter traveled from New York to join the effort. Farmers, students, and businessmen become emergency masons, plumbers, carpenters and electricians. In all, more than 11,000 hours of labor were donated, valued at over \$20,000.1,3 Greensboro churchwomen prepared and served meals to the men on the job. Union and non-union labor worked side by side. H. L. Coble was a "non-union contractor," but union members shelved old feuds to work. The AF of L waived overtime and doubletime, and even allowed members to work on Labor Day. From the beginning it was an around the clock operation.

Work proceeded so fast that by August 15 the building was up and interior work had begun. Painters who had promised to do the job in 30 days had it done in 11. The architects could hardly keep ahead of the job with the specifications. When Loenstein drew a line on the ground to outline a proposed addition of a diet kitchen, foremen had workers laying foundations along it before the architect got to the drawing board. Before blueprints and specifications were finished, brickwork was laid up to window level.^{1,3}

Money and labor were not the only donations made toward the new hospital. Fifteen thousand dollars worth of heating equipment, electrical wiring, and plumbing fixtures, as well as 240,000 concrete blocks and bricks had been given. The National Foundation for Infantile Paralysis sent respirators, hot pack machines, and hot pack materials, beds and cribs, refrigerators, tables, chairs, sterilizers, suction and oxygen equipment, fans, and blankets. Local merchants donated beds, radios, kitchen equipment, and other supplies.1 Red Cross volunteers worked over 12,000 hours making garments and hospital gowns.8 A Leaksville man, John H. Grogen, made a wooden lung, sister to the iron lung, which was later loaned to the hospital. The completed hospital unit was valued at over \$1,000,000.1,3

Doors Opened to Patients

On October 11, 1948, ninety-five days after the ground breaking, 116 patients from the two old units were transferred by ambulance to the new hospital, with nurses hand-pumping iron lungs. There was no fanfare nor opening ceremony, but many who had worked so hard to complete the job were on hand to watch the patients arrive. This was their best "thanks" for all their efforts in building the new medical center.

By this time the epidemic had been declared officially "over," but most of the county's 208 patients, and those of the surrounding counties, were still undergoing treatment. With new cases still coming in. the need for the hospital was as great as ever.1 The following years proved the worth of the Central Carolina Convalescent Hospital, not only to Guilford County, but to the whole state as well. In years such as 1954, when polio epidemics hit Caldwell County. the center operated at full capacity.¹⁰ It provided a maximum staff of 160 people. who worked with a staff of 23 local physicians, representing almost every medical specialty.7,10 It offered a wider range of treatment than any other Southeastern hospital operated exclusively for polio patients. Unlike many convalescent hospitals, it accepted the critically ill patients, who were placed in the isolation ward upon arrival. Here infants, children, and grown men and women lay side by side, fighting fever and paralysis. Iron lungs and rocking beds were used to help the more severely affected patients to breathe. A special operating room was provided for emergency use. Wards, recreational areas, and special physical and occupational therapy facilities made up much of the rest of the hospital.¹⁰

Soon after the hospital's opening it became obvious that some provision was needed for the education of alert minds as well as of paralyzed muscles. A search was begun to find qualified teachers who were not already involved in the program of a regular school. On November 29 the "school" at the hospital opened, with 44 pupils enrolled, representing all 12 grades. The Greensboro City School System administered the integrated program and the State Department of Public Instruction paid the three teachers' salaries. In ten years of operation the school taught 603 children. 11,12,13

The Need Declines

With the development of the Salk vaccine for polio, the population of the hospital began to decline in the second half of the 1950's. In February of 1958 there were only 28 patients at the center, and the Board of Trustees decided that it was economically unfeasible to operate it unless it could be used for other worthy causes as well as polio convalescence. On October 15 of the same year, the eight remaining patients at the Central Carolina Convalescent Hospital were transferred elsewhere as the center was closed. It was hoped that it would soon be reopened as a rehabilitation center.

The Guilford County Chronic Disease Survey, compiled in June of 1958, indicated that such a rehabilitation center was needed and would be of great benefit to the community. In February of 1960 the Rehabilitation Hospital was opened, using the facilities of the former convalescent hospital. Its purpose was the rehabilitation of disabled patients after definitive surgical and medical treatment had been completed. In spite of intensive efforts to continue its operations, the patient census was never high enough for the facility to become self-supporting, and it was forced to suspend operations on

November 15, 1961.¹⁷ Recently the facility was reopened as a nursing home, and it is being run as a private institution.

Conclusion

Even though the crisis is long over, and the physical plant of the Central Carolina Convalescent Hospital has been renovated for other uses, it still stands as a monument to the spirit of unity which springs up in any community where there is deep concern and desire to help afflicted people. Such a community was formed by the people of the entire Piedmont area of North Carolina in the summer of 1948. The Central Carolina Convalescent Hospital owes its success to these people, whose unselfish spirit brought into being the most effective weapon against polio—cooperation.

Acknowledgment

The author wishes to acknowledge the help of the following people who provided valuable background information: Mr. Norris Hadaway, Mr. T. W. Cope, Dr. Samuel F. Ravenel, Mrs. Mildred Simmons, Mrs. O. A. Smith, Wesley Long Hospital Administrative Staff.

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620 Anson Street, Apt. J-14 Winston-Salem, N. C.

Report on Trauma

SPONSORED BY THE NORTH CAROLINA CHAPTER
OF THE AMERICAN COLLEGE OF SURGEONS
COMMITTEE ON TRAUMA

In December, 1962, the North Carolina Chapter of the American College of Surgeons presented its first article in a series entitled "Report on Trauma." Since that time, 12 additional articles have appeared at varied intervals dealing with various aspects of the early management of acute trauma. Surveys by mail of approximately 1,000 physicians throughout the state of North Carolina have indicated that these articles have served a definite purpose in recalling the principles of early management of trauma and, in some cases, a pictorial demonstration of techniques involved. We have been quite pleased that a number of state medical societies along the east coast have requested, and published in their own journals, these articles as they have appeared.

Further it was the consensus of those physicians who replied to the questionnaire that a reproduction of these articles would serve a great purpose in again making them available to the physicians of the state who are most frequently called upon to manage these patients. Beginning with the article below, entitled "Transportation of the Severely Injured Patient," the entire series, with pertinent modifications, will be republished as it originally appeared.

TRANSPORTATION OF THE SEVERELY INJURED PATIENT

During the period from time of injury until a severely injured patient reaches a site at which definitive therapy can be undertaken he is usually in a totally helpless state. The most common urgent problems to be contended with during this phase are: (1) the maintenance of an adequate airway; (2) the control of hemorrhage; (3) the stabilization of fractures. Of these, the most critical and consistently demanding is the maintenance of an adequate airway — important not only in the transportation of the victim from the scene of the accident, but under any circumstance where the patient is unable to change his position.

During the early period of his care, usually a time of excitement, obvious injuries such as gross hemorrhage and deformed extremities are recognized for the most part, and receive at least adequate temporary care prior to and during transportation. It is during this phase that the patient is most likely to aspirate quantities of secretions, blood, and debris, while attention is directed to a grotesquely positioned extremity. As will be consistently referred to in this series of articles, the worst thing that can happen to any injury, regardless of its location, is the superimposition of an inadequate airway.

While the surest way of maintaining an airway is by the use of a tracheotomy, this is often not feasible and does itself require care. The simple expedient of placing and maintaining the unresponsive patient on his side, with an airway in place and with the head in a slightly dependent position so that secretions and blood will drain out of the mouth (as shown in figure 1) will in most instances, insure an adequate airway. Not shown in the diagram are appropriate straps for added stability. Sand bags, pillows, and/or blankets will contribute to the maintenance of this position. Ambulance stretchers, while narrower than that shown in the diagram are nevertheless adequate to allow such positioning.

Other supportive measures such as nasal oxygen, blood, or fluids, can easily be administered to such a patient.

A good deal of the responsibility for managing an injured patient in the early phase of his care rests with ambulance drivers and attendants. The physicians of the state, however, have an even greater responsibility in attending to the following details:



Figure 1

Through your County Medical Society insist:

- That your community ambulance drivers and attendants receive at least a basic first-aid course. These courses are being given regularly by your American Red Cross Chapter.
- 2. That your community ambulances be equipped to:
 - a. Maintain an adequate airway
 - b. Control hemorrhage
 - c. Splint fractures
 - d. Dress wounds
 - e. Render oxygen
 - f. Remove secretions from the oral cavity by suction.
- 3. That your community ambulances adhere to all rules and regulations concerning normal traffic control.

You can help your community ambulances by:

- 1. Releasing their stretchers as soon as practical from your emergency room.
- 2. Being available for emergency room care as soon as possible.
- 3. Showing appreciation for any improvement made by your ambulance attendants.
- Participating in the education of ambulance attendants concerning the transportation of the severely injured patient.

AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. Milton Terris, professor of preventive medicine at New York Medical College, has been named president-elect of the American Public Health Association. He will become president at the conclusion of the Association's ninety-fourth annual meeting which will be held in San Francisco October 31-November 4, 1966.

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North Carolina Medical Journal

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Instructions to authors appear in the January and July issues.

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JANUARY, 1966

SUGGESTIONS FOR AUTHORS

The North Carolina Medical Journal welcomes original contributions to its scientific pages, expecting only that they be under review solely by this Journal at a given time, and that they follow a few simple guidelines. The guidelines are as follows:

1. Subject Matter

Educational articles, especially those in which particular applications to the practice of medicine in North Carolina are developed, are one of the main objectives of this *Journal*.

Articles reporting original work by North Carolina physicians are invited, whether the work is done in a clinic, a laboratory, or both. The editor

and his consultants will evaluate the work by the usual criteria, including a proper discussion of previous work, control observations, and statistical tests where indicated.

Historical articles, especially those dealing with local history, are considered of real value and interest.

2. Manuscripts

An original and a carbon copy of the manuscript should be submitted, one for review by the editorial staff, the other by referees. The manuscript should be typed on standard-size paper, double-spaced, with wide margins (one inch on each side).

3. Bibliographic References

References to books and articles should be indicated by consecutive numerals throughout the text and then typed, double-spaced, on a separate page at the end of the manuscript. Books and articles not indicated by numerals in the paper should not be included, "unless an exhaustive review of the literature has been made on a subject of sufficient importance to warrant such a survey." Such a bibliography is seldom justified.

References will be much more valuable to the reader if they are given in a proper form and contain the full information necessary to locate them easily. The North Carolina Medical Journal follows the form used in the journals of the American Medical Association and the Index Medicus, giving the author's surname and initials, title of the article, name of the periodical, volume, inclusive page numbers, and the date of publication. It is believed that this style makes it easier for the reader to judge whether the reference is likely to prove useful to him, and enables him to locate it more quickly.

4. Tables and Illustrations

Tables and legends for illustrations should be typed on separate sheets of paper. The illustrations should be glossy black-and-white prints or line drawings. It is necessary to obtain permission from the author or publisher to reproduce illustrations which have been published elsewhere.

The North Carolina Medical Journal pays up to \$20 on the cost of cuts for any one article. This amount usually covers the expense of reproducing from two to five illustrations, depending on the size and type of cuts required. Line drawings and graphs are less expensive to reproduce than photographs. Authors may publish additional illustrations by paying the extra cost.

The style followed by this *Journal* will be, in general, that outlined in the Style Book issued by the Scientific Publications Division of the American Medical Association, John H. Talbot, M.D., director.

By following the above suggestions, writers will greatly expedite the publication of papers accepted by the *North Carolina Medical Journal*.

Fishbein M.: Medical Writing, ed. 2, Chicago, American Medical Association, 1948.

NEW DRUG REVIVAL

The Wall Street Journal for November 9, 1965, reports on the increasing numbers of new drugs introduced during the past two years and ascribes it to several factors, all of which make sense. The Food and Drug Administration is trying to speed up the processing of new drug applications, a task made more difficult by the new and stricter regulations which require proof of efficacy as well as safety. That government bureau is plagued by manpower shortages and, one suspects, a tradition of torpor—barriers that yield slowly even with the best intentions as a stimulus.

Not only the Wall Street Journal article, but information from a variety of sources indicates that drug companies are tending to invest their time and money in the development of drugs which represent an attack on a new field rather than in minor changes in a competitor's drug or new combinations of old drugs. (According to the Pharmaceutical Manufacturer's Association, none of 1960's top five manufacturers of diuretics were in that position in 1951, having fought their way up via new drug introductions.) With the cost of preparing an application so high, a more creative approach promises better results for both the companies and, from our point of view, the patients.

At the risk of being unpopular in some quarters, it should still be said that drug regulation in the United States has done the greatest good for the greatest number over the years, seen from the vantage point of life in a country where there is next to no drug regulation, or from the historic point of view in this country. Even in countries representing a state of regulation between the completely permissive and the United States status, there have been examples of drugs introduced by U. S. concerns that were accepted as effective and safe and then later proved less effective and fraught with toxic effects when introduced here. Our chief concern with regulation has been that it might stifle the development of the drugs that have done so much to change the medical world for the better, and now it seems that we can take heart from the way in

which good will, ingenuity, and the competitive instincts of the drug industry have fought their way through the barriers.

THE PRACTICAL FEMALE

The Kinsey report on "Sexual Behavior in the Human Female" has just been issued as a pocketbook—with an unembellished cover —and a copy was sent to this Journal. It seemed an awfully large dull tome when first issued, and now seems a somewhat smaller dull tome, but in both cases a useful one for psychologists and psychiatrists and perhaps others as well. At any rate, the book happened to fall open at a place in which the response of women to seeing pictures of nude men was catalogued. It may be briefly described as almost nonexistent. and his fellow authors comment that women have no earthly idea what pleasure men get out of looking at such pictures, since pictures are in themselves incapable of any sort of relationship with them.

Perhaps in that one observation, neatly tied up as a percentage, one has an expression of what we all know to be true: that women are better at seeing through sham and pretense than are men. Perhaps this same restriction of imagination is related to the always puzzling small size of the ranks of women artists, composers, and the like. If there is some hormonal cause for the difference, wiping out the pornography market might be made a pharmacologic matter; it seems that no other approach will ever work.

One wonders, though, if due weight was given by the Kinsey group to the talent ladies have for dissembling. They probably did not; which puts this observation under a cloud, like many of the others. However, they could do the study over again and come up with some objective answers. In the *Scientific American* for April, 1965, Eckhard Hess describes his experiments on the relation between pupil size and various mental processes. While we all recognize the response of the pupil to light, we appreciate its reaction to thought subliminally, if at all. Hess found that when a person looks

at a picture of something pleasurable—his first try was showing his assistant a pin-up—his pupil dilates. The Kinsey folks could easily check up on the ladies they were questioning. And the ladies would do well to remember that their own sex has long recognized that a dilated pupil denotes pleasure, as shown by the historical employment of belladonna as a cosmetic.

FILLERS FROM DR. BUCHAN

This issue of the Journal contains the first of a series of "fillers" taken from the pages of William Buchan's "Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc.," published in Philadelphia by Richard Folwell in 1799, and adapted to the "Climate and Diseases of America" by Isaac Cathrell. The American edition was taken from the second British edition of the book, published in London in 1785, the first edition having appeared in 1769. The volume which yielded these little gems was given to the Bowman Gray library by Dr. Ernest C. Bennett of Elizabethtown, and is in good condition despite the evidence that it was used heavily over the years.

William Buchan (1729-1805) was a Scot whose attempts to write for the lay public were not always well received by his contemporaries, to judge by his own complaints. His best known book was published after "Domestic Medicine"; entitled "Advice to Mothers," it came out in 1803 and enjoyed widespread popularity in the early part of the nineteenth century.

Perhaps the chief pleasure of reading a book like "Domestic Medicine" comes from recognizing the eternal value of good sense, which is what makes Buchan appealing. He was obviously a cautious man, with the welfare of his patients at heart, and the courage to buck the majority as he saw fit. His wry sense of humor was no doubt a source of comfort to him as it is amusement to us. Like our earlier series of fillers from the writings of another wise man, Alan Gregg, it is hoped that the present run will prove as provocative as some of the articles they buoy up.

EGO NON COGITO, ERGO ID NON EST

While even the late Fred Allen would probably have been willing to accept Descartes' ultimate minimum in belief, it is doubtful that he or other sceptics would grant a hearing to the allied proposition expressed in the foregoing title, and would feel that if they didn't think of it, it couldn't exist.

What calls this to mind is a piece in the British Medical Journal, reported in the public press, about a woman who was told at the age of 5 years that she would die when she was 43, and who actually died at the age of 43. One hears such stories from time to time, especially about the natives of New Guinea and other remote places. There are well educated, sophisticated people in this and other countries who firmly believe that they have witnessed similar incidents. Like the wish to believe in flying saucers, interest in these phenomena is persistent.

Physicians are probably a little more willing than most professions connected with science to grant a hearing, at least, to such tales. Even if they are made up of whole cloth, they tell us something about the person who brings them. We see too much of exposed basic humanity, flesh and spirit, to assign narrow limits to what might happen to people, background and circumstances being right.

To assist the well-meant endeavours of the humane and benevolent in relieving distress; to eradicate dangerous and hurtful prejudices; to guard the ignorant and credulous against the frauds and impositions of quacks and imposters; and to show men what is in their own power, both with regard to the prevention and cure of diseases, are certainly objects worthy of the physician's attention.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 21.

The President's Page

MANDATORY UTILIZATION REVIEW

Whether we like it or not, the members of the medical profession in this State are intimately involved in certain provisions of the health insurance program for the aged. For it to have any chance of successful implementation it is most essential that there be informative and meaningful communication between those responsible for administering the program and individuals and organizations who will be affected by it, or who have knowledge or experience to contribute to it. Firm lines of communication have been established by the A. M. A. and the Department of Health, Education and Welfare.

One of our major professional concerns is the utilization review program and the particular requirement for a utilization review plan under the hospital insurance law. Current emphasis on this problem has been brought into focus by the enactment of Public Law 89-97 but all familiar with the subject are aware of the profession's earlier efforts in this area which gave reassurance of professional concern for effective utilization to the entire public and to all third parties, and to all public programs including not just the Social Security provisions, but also Title XIX and other welfare provisions.

The implementation of this phase of this new law imposes on us a responsibility which we have already recognized: that we accommodate and encourage and expand the existing practices in certain areas, under professional direction, of assuring quality medical care to patients through sound utilization of hospital facilities and services. As a provider of services, we are in a responsible position of determining how utilization reviews can best be done. individual physician joined with the members of the staffs of the hospital in which he works, can give support to the over-all program in establishing a utilization review plan and give evidence of its effective oper-As a provider of services we find ourselves sharing in governmental administrative responsibilities with the state agencies, and the intermediaries in the process of implementing the requirement of the law.

It is of obvious advantage for the physicians associated with a "hospital" or "extended care facility," which the law defines. to have his institution be a participant in the program. This requires the establishment of eligibility. Such providers may participate if they meet the defined conditions of law and the additional conditions of health and safety that may be established. In general, these additional conditions cannot exceed the comparable requirements of the Joint Commission on Accreditation of Hospitals. Appropriate State Agencies will be used to ascertain whether the appropriate requirements are met (in our case, the State Department of Health). Upon them will be the responsibility of certification, of providing consultation to marginal institutions that may have problems in qualifying and to insure coordination between the work the State must do for the program and other on-going State activities, such as licensing. facility construction programs and other responsibilities the State Health Department may have under North Carolina law.

A major part of the job to be done by the Administrating Agency—The Department of Health—in North Carolina, is to receive applications from hospitals, extended care facilities and home health agencies to determine (and certify to the Federal program) whether these institutions and agencies meet the requirements for participation in the program. For this, the deadline is July 1966, when the program goes into effect. Hospitals accredited by the Joint Commission on Accreditation of Hospitals are presumed to meet the conditions of participation except for the requirements of utilization review. Arthur Hess says that a qualified utilization review mechanism can normally be assured through an appropriate submittal by the hospital of a statement of its plans. State Agency will work with the medical

profession, hospital association and the fiscal intermediary to take judicial cognizance of steps being taken in the professional community to assure not only the creation, but the likelihood of effective functioning of these plans.

Since the medical profession has a basic role in insuring proper and effective utilization of hospital beds and services, it is suggested that all medical societies, and all medical staffs of the hospitals of our State study, plan, create, and implement a mechanism for utilization review. It is most important that there be physician participation so that there will be physician control, in line with his professional capacity and responsibility. Only the individual physician can admit patients to a health facility, only he can order studies, only he can discharge the patient. He, with his colleagues, sets the pattern and develops standards of proper medical management and proper utilization for the professional community. Space here does not permit extended discussion of this problem. Material and guidelines are available which have been prepared by the A. M. A. The booklet, Utilization Review, will be found to be most helpful.

With a coordinated effort, involving the State Board of Health, the N. C. Hospital Association, The Medical Society of the State of North Carolina, the medical staffs of our hospitals, and the individual physician, appropriate, effectively functioning utilization review mechanism can be established. Our participation and strong leadership in this program will give assurances for continued physician control.

GEORGE W. PASCHAL, JR., M.D. President

1110 Wake Forest Road Raleigh, N. C. 27604

THE 1966 "AIRCADE"

A one day meeting on citizenship, legislation, and politics sponsored by the Chamber of Commerce of the United States is scheduled for the Raleigh Memorial Auditorium, Wednesday, March 9, 1966, 9:25 A.M. to 3:15 P.M. Subjects to be treated, led by national experts, are the 89th Congress and national issues, elections and political action, citizenship, and leadership.

The cost is only \$8.00, including luncheon. Send check to the Host, Raleigh Chamber of Commerce, P. O. Box 2978, Raleigh, N. C. 27602, and request your luncheon ticket.

MEDPAC of North Carolina urges physicians and their wives to attend this "Aircade."

Bulletin Board

Coming Meetings

Conference of County Medical Society Officers and Committeemen—Carolina Hotel, Pinehurst, January 28-29.

Watts Hospital Symposium—Watts Hospital, Durham, February 18-19.

North Carolina Mental Health Association, Annual Meeting—Queen Charlotte Hotel, Charlotte, March

Duke University School of Medicine and the American Academy of Orthopaedic Surgeons, Postgraduate Cruise Course on Fractures and Other Injuries—MS Europa from New York, March 14; West Indies.

Bowman Gray School of Medicine of Wake Forest College, Postgraduate Course in Obstetrics and Pediatrics—Winston-Salem, April 12-14.

North Carolina Chapter, American College of Surgeons Meeting—Hotel Robert E. Lee, Winson-Salem, April 14-16.

Medical Society of the State of North Carolina, 112th Annual Session—City Auditorium, Asheville, April 30-May 4.

North Carolina Heart Association, 17th Annual Meeting—Jack Tar Hotel, Durham, May 18-19.

American College of Physicians, Postgraduate Course, "Neurology for the Internist" — Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, June 15-18.

WATTS HOSPITAL MEDICAL AND SURGICAL SYMPOSIUM

The Watts Hospital Medical and Surgical Symposium will be presented in Durham on Friday and Saturday, February 18 and 19. The Symposium has been approved for ten hours credit by the American Academy of General Practice.

Symposium headquarters will be the Jack Tar Hotel. Registration will begin at 9 A.M on Friday. There is no registration fee.

Subjects and speakers will be as follows:

Friday—February 18

Roston W. Williamson, M.D., Presiding 9:00 A.M.

Registration

10:00 A.M.

Clinical Evaluation of Thyroid Function—F. Raymond Keating, Jr., M.D.

10:45 A.M.

The Diagnosis of Obstructive Jaundice—John M. Beal, M.D.

11:30 A.M.

Coffee Break

11:45 A.M.

Psychological Aspects of Drug Response Differences—Albert J. Silverman, M.D.

12:00 P.M.

Ladies Luncheon-Fashion Show—Jack Tar Hotel 2:00 P.M.

D. Edmund Miller, M.D., Presiding

The Patient with Unexplained Fever—Wesley W. Spink, M.D.

2:45 P.M.

Doctors and the Law—Charles J. Frankel, M.D. 3:30 P.M. Intermission

3:45 P.M.

Rubella, with Particular Reference to Fetal Infection—Frederick C. Robbins, M.D.

7:00 P.M.

Social Hour and Dinner Dance-Jack Tar Hotel

Saturday—February 19

8:15 A.M.

"Hunt Club Breakfast"—Jack Tar Hotel 9:30 A.M.

Morris Jones, M.D., Presiding

The Current Status of Present Day Contraception—Nichols Vorys, M.D.

10:15 A.M.

Hyperparathyroidism—Advances In Diagnosis and Treatment—David M. Hume, M.D.

11:00 A.M.

Coffee Break

11:15 A.M.

Pathophysiology and Management of Pulmonary Embolism—John L. Patterson, Jr., M.D. 12:30 P.M.

Watts Alumni Luncheon—Watts Hospital Cafeteria

1:30 P.M.

Case presentations and Informal Discussions of Clinical Problems—Watts Hospital 2:45 P.M.

Coffee Break

3:00 P.M.

Panel Discussion: Transplantation—Watts Hospital

James F. Glenn, M.D., Moderator 6:30 P.M.

Cocktail Buffet-Blair House

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

A Community Psychiatry Section being developed at the University of North Carolina Psychiatric Center will train people to help staff a proposed statewide network of community mental health centers.

"We envision the University as a fountainhead for training mental health manpower for the state," says Dr. William G. Hollister, director of the new section at UNC and formerly the chief of the Community Research and Services Branch of the National Institute of Mental Health at Bethesda, Md.

"We're setting up our section within the Depart-

ment of Psychiatry to achieve this goal and we expect to link ourselves with the Department of Mental Health at the (UNC) School of Public Health, the (UNC) Institute for Research in Social Science, the (UNC) departments of sociology, anthropology and psychology and the N. C. Department of Mental Health in Raleigh."

Dr. Hollister plans to use the facilities of the N. C. Department of Mental Health as "a living laboratory" so that the training programs here will be "practical and service oriented."

North Carolina plans tentatively for community mental health centers in 26 areas of the state within the next five to 10 years.

Dr. J. Wilbert Edgerton, a native of Pikeville in Wayne County, who has been regional program director for the National Institute of Mental Health in Chicago for five years, has joined the new Community Psychiatry Section to coordinate the field training.

A four-point "revolutionary proposal" under which medical schools would help bring high quality care to patients in community hospitals was presented in Philadelphia recently at the annual meeting of the Association of American Medical Colleges.

"If medical schools are really concerned with the quality of patient care, they must also be concerned with community hospitals," Dr. Robert R. Cadmus of Chapel Hill told the AAMC's Teaching Hospital Section.

Dr. Cadmus is the consulting director and former director of N. C. Memorial Hospital and is chairman of the Department of Hospital Administration at the University of North Carolina School of Medicine.

He reviewed in his talk a three-year demonstration project conducted at UNC to ferret out some of the needs of community hospitals which could be met by universities and major teaching hospitals.

Six appointments to the medical faculty of the University of North Carolina were announced recently by Chancellor Paul F. Sharp, following approval of President William C. Friday and the Board of Trustees.

Dr. Mario C. Battigelli, a native of Italy, will join the Public Health and Medical School faculty December 1. He holds degrees from the University of Florence, and the University of Pittsburgh, where he has researched and taught since 1959.

James R. Turner is the new Assistant Dean of Medical Administration. He received his degree from Knox College and was previously administrative associate to the Dean in the Biological Sciences Division at the University of Chicago.

Dr. Harry Stephen McGaughey, Jr., replaces Dr. Robert A. Ross as chairman of the Department of

Obstetrics and Gynecology. Dr. Ross will continue on the faculty as a professor. McGaughey, a native of Wisconsin, was educated at the University of Wisconsin. Since 1954, he has been on the faculty at the University of Virginia.

Three assistant professors were appointed. They are Dr. Geoffrey Haughton of Leeds, England; Dr. Charles Edward Rackley of Burlington; and Dr. Mario Perez-Reyes of Mexico.

* * *

An electronic computer "listening" to the breathing of a patient in a medical laboratory here can calculate almost instantaneously the stiffness of the patient's lungs, the resistance to the flow of air between his nose and lungs, and the amount of work he has to do to breathe.

The computer gathers its data and produces medical information just as rapidly as the patient in breathe.

Its fantastic speed makes it possible for hundreds of breaths to be studied at a time. With traditional manual calculations, breathing studies are a tedious, time-consuming task limited to only one breath at a time.

The computer's speed, its error-free mathematics, and the ability of specially trained engineers to adapt electronics to medical needs is helping medical scientists understand more about the actual condition of a patient's breathing apparatus in such lung disorders as asthma and emphysema.

Computers are at the heart of a new Bioengineering and Biomathematics Unit being developed within the Division of Cardiovascular and Thoracic Surgery at the University of North Carolina School of Medicine.

Some of the most interesting applications include:

Electrical engineering techniques in the study of nerves and nerve networks in the human body to ind out how they work.

Hydraulic engineering principles in understanding how blood flows and how the heart pumps.

Many aspects of mechanical engineering in the study of the bony structure of the body and the baffling network of muscles.

Dr. Robert R. Cadmuz, chairman of the Department of Hospital Administration at the University of No:th Carolina School of Medicine, has been appointed to a state Health Task Group and to a national Advisory Committee on Hospitals and Clinics.

He will serve on a Health Task Group within an Emergency Resource Planning Committee which Governor Dan K. Moore has established to assist him in an emergency preparedness program for the state.

Assistant U. S. Surgeon General Leo J. Gehrig appointed Dr. Cadmus to the U. S. Public Health Service's Advisory Committee on Hospitals and



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylo-

lytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin $3X^{**}$ (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg. *Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.



LAKESIDE LABORATORIES, INC.

Milwaukee, Wisconsin 53201

Clinics. The term begins immediately and continues until June 30, 1968.

Dr. Cadmus was director of N. C. Memorial Hospital here for 12 years before assuming the chairmanship of the UNC Department of Hospital Administration.

The National Heart Institute has approved a \$91,000, five-year grant to the University of North Carolina here for the use of electronic computers in studying what goes on in the human body during breathing.

The project director is Dr. Richard M. Peters, professor of surgery in charge of chest surgery and co-director of the Clinical Heart-Lung Laboratory at the UNC School of Medicine.

The Eastern Psychiatric Research Association of New York has awarded the 1965 Thornton Wilson Award to a University of North Carolina psychologist.

Dr. Irvin I. Gottesman, an associate professor in the Department of Psychiatry at the UNC School of Medicine, has received the \$500 award for the most outstanding scientific paper in genetic and preventive psychiatry.

The paper, entitled "Schizophrenia in Twins: 16 Years of Consecutive Admission to a Psychiatric Clinic," reported on a unique study of the mental status of the brothers and sisters of twins hospitalized at Maudsley Hospital in London, England, with a diagnosis of schizophrenia.

The co-author of the paper was James Shields of the Maudsley Hospital in London.

Biopsy needles inserted painlessly into a patient's chest to remove tiny bits of the lining of the lungs are proving valuable at N. C. Memorial Hospital in diagnosing cancer and tuberculosis.

Dr. Frank S. Johnston, Jr., a fellow in medicine at the University of North Carolina School of Medicine, reported at the annual meeting of the Southern Medical Association that 51% of the patients with abnormal fluid in the chest were diagnosed with, or suspected of having, cancer or tuberculosis on the basis of needle biopsies.

The scientific paper presented represented the combined efforts of Dr. Johnston, Dr. Robert R. Huntley of the UNC medical staff, and Dr. Robert L. West, former chief resident in pathology at N. C. Memorial Hospital.

Two assistant directors of N. C. Memorial Hospital have been appointed.

Ronald H. Hutton, administrative assistant at Memorial Mission Hospital in Asheville for the past year, has been appointed assistant director for long-range planning. He succeeds Roger E. Miles, who has become manager of professional services at the Medical College of South Carolina in Charleston.

Fred Parker, director of the Outpatient Department for three years, has been promoted to assistant director of N. C. Memorial Hospital. He will have charge of ambulatory patient services, including the Outpatient Department Employee Health Service, patient registration, emergency room, telephone and paging service, bed control, information desk, mail and message service, Dietary Department, and speech and hearing services.

A simple, automated chemical test used to detect phenylketonuria was explained by Dr. George K. Summer, a UNC pediatrician, at a meeting of the International Congress of Pediatrics in Tokyo, Japan, recently.

The North Carolina State Board of Health has conducted field tests, using the new technique to check blood samples of newborn babies in several North Carolina cities.

Miss Ann Lou Jamerson, a 1959 graduate in physical education from the University of North Carolina at Greensboro, has been appointed assistant director of physical therapy at N. C. Memorial Hospital.

She came here from Memorial Mission Hospital in Asheville. Before going to Asheville she had been with Sequoia Hospital in Redwood City, Calif., for five years.

Graduation ceremonies were conducted at N. C. Memorial Hospital recently for the fourth class of operating room technicians.

The program, the first of its kind in the state, was established under a contract with the U. S. Labor Department to train unemployed and underemployed persons to meet a critical need for operating room technicians in hospitals.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Officials at Duke University have announced a major frontal assault on the problems of growing old.

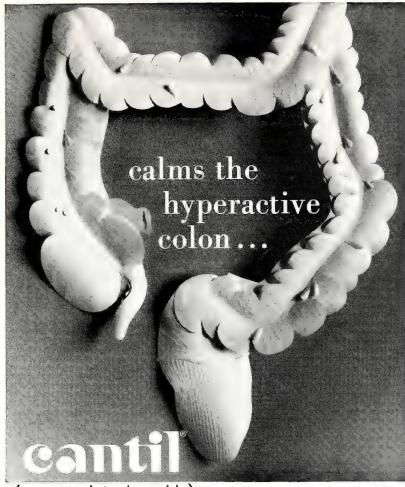
A regional information, referral, and counseling service for older people and for families requiring help in coping with the problems of the aged will be set up at Duke.

The project also will involve a wide range of new training programs to provide counselors in aging and to provide medical specialists to help improve patterns of care for the elderly.

Announcement of the project was made by Dr. Douglas M. Knight, Duke president.

"The project actually will be an extension of our research-oriented Regional Center for the Study of Aging," Dr. Knight said. "It will be designed to focus the fruits of 10 years of research on the problems of people in the region."

The new concept announced by Dr. Knight will



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withholdinglaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg, per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957



involve a refocusing of the center's operation as well as an expansion of its mission. In light of this, the Duke Council on Gerontology, under which the university's research effort in aging was stated in 1955, has been expanded and renamed the University Council on Aging and Human Development.

Dr. Ewald Busse, professor and chairman of the Duke department of psychiatry, is chairman of the council and director of the center, which has been broadened to the Center for the Study of Aging and Human Development. Dr. Knight said the center would work closely with a number of state and local agencies to provide counseling services and to train other counselors.

Dr. Carl Eisdorfor has been named director of training and research coordinator of the expanded center.

He said the new training programs will include: Training of such people as doctors, nurses, social workers, and public health workers for counseling.

Training of researchers in aging and human development.

A two-year training program in behavior and behavioral physiology in aging for people already professionally trained.

A training program in geriatric psychiatry for psychiatrists who want to develop special skills in care of the aged.

The Duke center was made the first Regional Center for the Study of Aging in 1957 by the National Institutes of Health. Its operation was underwritten with a \$1.5 million federal grant.

A drug that may solve one of the major problems in undersea and space exploration and in hyperbaric medicine was reported for the first time at an international medical conference here.

Dr. Aaron P. Sanders of the Duke University Medical Center outlined experiments indicating that the drug succinate is an "effective protective agent" against the potentially poisonous effects of oxygen at high pressures.

Dr. Sanders outlined experiments in which three groups of rats were subjected to 90 minutes exposure to pure oxygen at pressures equivalent to about 170 feet beneath the ocean.

Ninety per cent of the animals given only a saline injection prior to exposure died before the 90 minutes were up. Fifty per cent of the rats injected with a sugar solution died during exposure, 30 per cent had severe symptoms of oxygen poisoning, and 20 per cent appeared normal.

However, all of the animals injected with succinate "were normal in appearance, alert and active." Six animals were observed for six days and showed no after-effects, Dr. Sanders said.

A surgeon from the Duke University Medical Center has been elected to two top-ranking posts in the Southern Medical Association.

Dr. J. Leonard Goldner, professor of orthopaedic gery, was named chairman of the executive committee and chairman of the council at the association's annual meeting in Houston, Texas. Dr. Goldner has served as the association's councilor from North Carolina.

\$ \$ t

A Scotsman who is holder of more than a dozen American newspaper awards has joined the staff of the Duke University Office of Information Services.

Dominic Crolla, 38, has assumed responsibility for reporting news of the Duke Medical Center, according to an announcement by Clarence E. Whitefield, director of the Office. The appointment was effective Dec. 1.

Crolla came to Duke from the staff of the Rocky Mountain News, Denver, Colo. He formerly was with the Tucson (Ariz.) Daily Citizen, where he earned national and state awards for medical writing, feature writing, general news reporting, sports writing, and photography.

At Duke, Crolla will be in charge of publicizing research, teaching, and patient care in the Schools of Medicine and Nursing and the University Hospital. He will concentrate on reporting major programs and events for state, regional, and national media. He succeeds Wes Lefler, who has joined the News Bureau of the University of North Carolina at Chapel Hill.

An "alarming increase" has been reported in the number of poison cases treated at the Duke Poison Control Center—610 this year compared

with 549 a year ago.

And what makes the upward trend alarming, says Dr. Jay M. Arena, director of the center, is that children under three years of age were involved in almost three-fourths of the poisoning incidents.

In all, 406 poisoning victims were children under three, an increase of 112 over 1963-64.

Dr. Arena noted that of the total number of cases, 41 were deliberate suicide attempts—18 of them by young people between 9 and 20 years of age.

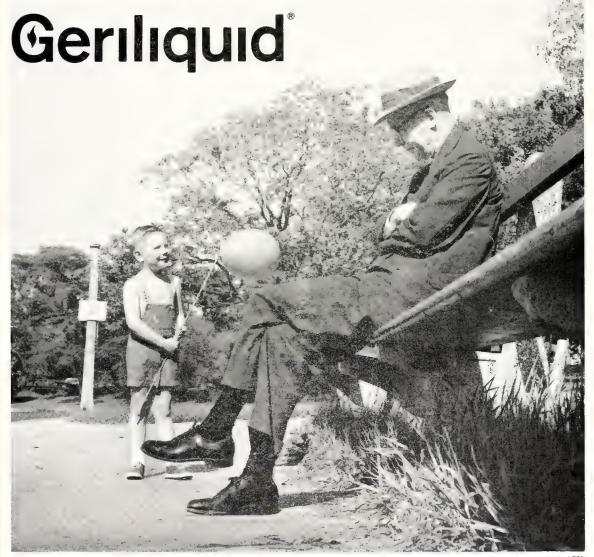
In his year-end report, the Duke physician noted that the major category of poisoning agents consisted of drugs and medicines—aspirin the chief culprit. Other major poisons included household products, such as bleaches and detergents, furniture polish, floor wax and kerosene, and insecticides and pesticides. Sedatives and tranquilizers also were listed.

Internal medications were implicated in 249 of the cases and household, farm and commercial products in 204.

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.



IN BRIEF: Composition: Each 5 ml, contains: niacin 75 mg, and aminoacetic acid (glycine) 750 mg, in a palatable sherry wine base; alcohol 5%. Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.



A stinging caterpillar caused the sole insect-bite case, the report showed.

Dr. Arena blamed carelessness for the number of accidents involving children and charged that parents all too often fail in their responsibility to protect their children.

"Poor supervision in the home is the reason so many children become poison victims," he said, adding that this is particularly true in those homes where both parents work.

"I've said it time and time again: the American home is a hazard instead of a haven and it is high time that parents realized their responsibility in preventing these tragic accidents," he said.

Dr. George D. Wilbanks, Jr., assistant professor of obstetrics and gynecology, has received a grant from the Damon Runyon Memorial Fund for Cancer Research to find out what happens when a tumor becomes malignant and begins to invade normal tissue.

With the aid of the \$22,000 grant, Dr. Wilbanks will take instant-by-instant microscopic pictures of tumor cells as they become malignant and begin to invade normal cells nearby. The cells will be placed in test tubes and time-lapse cinematography will be used to record the tiniest changes as they occur.

Dr. Wilbanks explained that there are few studies available to determine exactly what takes place at the cellular level when a "preinvasive" tumor becomes active and begins to spread to other tissues.

Four people were honored recently for 30 years of service at the Duke University Medical Center.

Initiated into the 30-Year Club were Dr. Norman F. Conant, James B. Duke professor of microbiology; Dr. William M. Nicholson, professor of medicine; Claudius P. Jones of the Department of Obstetrics and Gynecology; and Henry Pickett of the Medical Illustration Department.

Service pins and certificates of recognition were presented to the four by Charles H. Frenzel, administrative director of Duke Hospital; and Dr. William G. Anlyan, dean of the Duke School of Medicine.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Plans have been announced for the establishment of a Behavioral Sciences Center at the Bowman Gray School of Medicine. The center, supported by grant funds of more than \$600,000, will foster the development of a unique program of research and training in marital health, family life education and human sexuality.

The new program is designed to train medical students, graduate students, physicians and non-

medical educators to deal with marital and family life problems. Its aims also include the development of training materials and the production of well-trained personnel to support instructional programs at educational levels ranging from secondary schools to medical schools.

The most recent grant to be awarded for the program came from the Commonwealth Fund of New York City and amounted to \$180,600. Other support includes a \$150,000 grant from the Mary Reynolds Babcock Foundation, a \$20,000 grant from the Public Welfare Foundation, Inc., and a recent \$250,000 gift from an anonymous donor.

The Behavioral Sciences Center represents a broad expansion of the medical school's previously established marital health and family life program. Recent grants will provide for three new faculty positions and will enable the medical school to award fellowships to trainees in the behavioral sciences.

In announcing the latest grant, Quigg J. Newton, president of the Commonwealth Fund, said, "The grant is made in recognition of the pioneering work which Bowman Gray has done in this important field. We hope the program . . . will serve as a model."

Dr. Clark E. Vincent, professor of sociology and immediate past president of the National Council on Family Relations, has been named director of the center. Dr. Frank R. Lock, professor and chairman of the Department of Obstetrics and Gynecology and the man who formulated the program, will serve as clinical and medical director.

Other members of the Behavioral Sciences Council are Mrs. Ethel M. Nash, assistant professor of preventive medicine and president of the American Association of Marriage Counselors; Dr. C. Nash Herndon, professor and chairman of the Department of Preventive Medicine and Genetics; Dr. Lucile W. Hutaff, professor of preventive medicine; and Dr. Richard C. Proctor, professor and chair man of the Department of Psychiatry.

The programs of the Behavioral Sciences Center will be multidisciplinary, with faculty members from at least eight departments participating in the training and research activities.

Dr. Felda Hightower, associate professor of surgery at the Bowman Gray School of Medicine, is the editor of the 1965 edition of "Transactions of the Southern Surgical Association." The 522-page book, released recently by J. B. Lippincott Co., is published annually by the Southern Surgical Association. It contained 39 scientific papers which were presented at the 76th annual meeting of the association.

Dr. R. Winston Roberts, professor of ophthalmology, has been awarded the American Academy of Ophthalmology and Otolaryngology Honor Award for his work in the educational and investigative

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: ACTIONS AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg, of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep inframuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

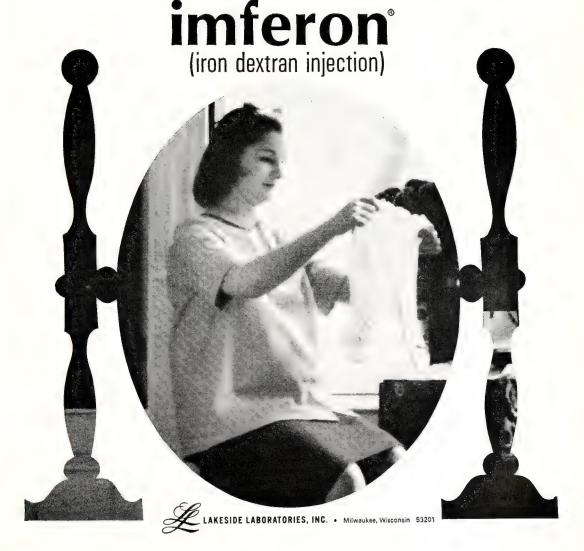
PRECAUTIONS: It sensitivity to test doses is manifested, the drug should not be given. Inferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves



fields of ophthalmology. The presentation was made at the organization's annual meeting Nov. 14-19 in Chicago, Ill.

Dr. Roberts also taught a course on "Early Diagnosis of Glaucoma" at the meeting.

An orthopedist at the Bowman Gray School of Medicine has developed a new research technique which promises to remove some of the mystery which now surrounds the formation and resorption of bone tissue.

Dr. Homer A. Paschall, assistant professor of orthopedics, has combined the principles of autoradiography with electron microscopy for the study of bones.

Both procedures are unique in the field of bone research. Dr. Paschall is one of only five researchers in the United States—one of eight in the world—who are currently studying the structure and function of bone cells by means of the electron microscope. He and Dr. David Cameron of Sydney, Australia, are the only two scientists who have incorporated the use of isotopes in the studies.

Dr. Paschall was recently awarded an \$87.600 grant by the National Institutes of Health to support three years of bone investigation, using the new methods.

* * *

Dr. Eben Alexander, Jr., professor of neurosurgery, was visiting professor of neurosurgery at the University of Wisconsin School of Medicine Nov. 2-3. He spoke on "The Diagnosis and Treatment of Paraplegia" and "Treatment of Arteriovenous Anomalies of the Brain."

Dr. Clark E. Vincent, professor of sociology, delivered the Visiting Scholar Lecture at Western Reserve University School of Medicine Nov. 11-12. He lectured on "Marital Health and Communication" and conducted a seminar on "Stigmati in Sex Research."

Dr. W. Joseph May, assistant professor of clinical obstetrics and gynecology, was installed as president of the Forsyth County Medical Society at the organization's November meeting. He succeeds Dr. Louis deS. Shaffner, associate professor of surgery. Dr. Richard T. Myers, associate professor of surgery, was elected president-elect and Dr. C. Glenn Sawyer, professor of medicine, was elected vice president.

Clyde T. Hardy, associate dean of the Bowman Gray School of Medicine, was named chairman of the Committee on Liaison and Public Relations of the Medical Group Management Association at the annual meeting of the association in Portland. Oregon.

Dr. Harold D. Green, professor and chairman of the Department of Physiology, was a member of

the guest faculty for the 17th annual Symposium on Heart Disease in Seattle, Wash. He lectured on "Clinical and Laboratory Methods for Evaluation of Occlusive and Vasospastic Peripheral Vascular Disease," "Influence of Vasospasm and Arterial Occlusion on Pulse Transmission and Heat Transfer to Skin," and "Evaluation of Medical Therapy, Sympathectomy and Vascular Surgery in the Management of Occlusive Vascular Disease."

AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course: Neurology for the Internist Bowman Gray School of Medicine, June 15-18, 1966

The American College of Physicians will present Postgraduate Course No. 19 - "Neurology for the Internist" - at the Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, June 15-18, 1966.

James F. Toole, M.D., F.A.C.P., professor of neurology and chairman of the department at the Bowman Gray School of Medicine, will be the director.

This course has been designed for internists and family physicians who require practical information to assist them with diagnosis and treatment of neurologic problems which they see in practice. The topics to be covered and the case presentation method of teaching have been selected with this in mind. Particular attention will be directed at advances in diagnosis and management of cerebral vascular diseases.

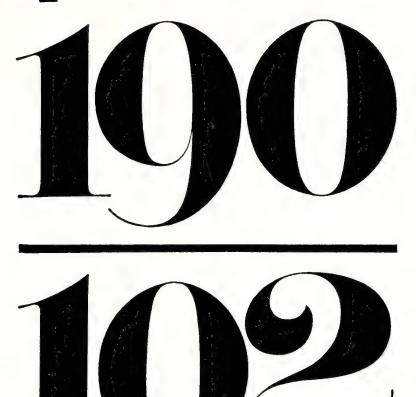
One part of the course will be concentrated on disorders of consciousness and mentation, with emphasis on treatable conditions. Another will include neurologic disorders related to metabolic abnormalities or other systemic diseases. The significance of headache, convulsions, and vertigo will be discussed at length, and a practical approach for evaluation and therapy will be given for each. New diagnostic techniques will also be considered in detail, and the indications and limitations of these procedures will be emphasized.

An objective of the course will be to encourage audience participation. A number of case presentations and clinicopathologic conferences will be included, with the expectation that each participant will work out the problem concomitantly with the course faculty.

The guest faculty will be as follows:

Dr. Robert B. Aird, professor of neurology and chairman of the department, University of California School of Medicine, San Francisco; Melvin Cole, assistant professor of clinical neurology, New Jersey College of Medicine and Dentistry, Jersey City; Thomas W. Farmer, professor of neurologic medicine and head of the division, University of North Carolina School of Medicine, Chapel Hill; Joseph M. Foley, professor of neurology and chair-

the price of "success"



Hypertension has been called the price of success...and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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EACH SCORED TABLET CONTAINS: Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.



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man of the department, Western Reserve School of Medicine, Cleveland, Ohio.

Also, Drs. Albert Heyman, professor of neurology and chairman of the department, Duke University School of Medicine, Durham; Aneel Patel, fellow in pediatric neurology, Western Reserve School of Medicine and Cleveland Metropolitan General Hospital, Cleveland; Fred Plum, professor of neurology and chairman of the department, Cornell University Medical College, New York City; E. Pierson Richardson, Jr., assistant professor of neuropathology, Harvard Medical School, and neuropathologist and neurologist, Massachusetts General Hospital, Boston.

Bowman Gray faculty members to be included in the postgraduate course faculty are:

Drs. Eben Alexander, Jr., professor of neurology and chairman of the section; Monroe Cole, assistant professor of neurology; Joseph J. Cutri, assistant professor of psychiatry; Courtland H. Davis, Jr., associate professor of neurosurgery; Richard A. Janeway, instructor in neurology; David L. Kelly, Jr., instructor in neurosurgery; William W. Mc-Kinney, assistant professor of neurology; Isadore Meschan, professor of radiology and chairman of the department; J. Rupert Ravens, assistant professor of neuropathology; Edward V. Spudis, assistant professor of clinical neurology; and Dr. Toole, who is also director of the course.

Registration fees are \$60 for A.C.P. members and \$100 for non-members. Limits have been set at a minimum of 50 and a maximum of 150 registrants.

Registration forms and requests for information are to be directed to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Headquarters for the course will be the Robert E. Lee Hotel in Winston-Salem. Other accommodations may be obtained at the Sheraton Motor Inn and Howard Johnson's Motor Lodge, also at Winston-Salem.

Transportation will be provided from the above hotels to the Bowman Gray School of Medicine. When writing for reservations at these hotels, physicians are asked to identify themselves with the American College of Physicians and this particular course.

NORTH CAROLINA HEALTH COUNCIL

Health interests of North Carolinians were considered at the annual meeting of the North Carolina Health Council in Durham on Dec. 7. Representatives from 61 state-wide organizations and agencies with health related interests attended the meeting. C. Scott Venable, Raleigh, is president of the Council.

The effects of the Medicare program on institutions and individuals was the focus of the one-day meeting.

James W. Murray, Atlanta, Regional Director of the Social Security Administration, outlined provisions of Public Law 89-97, popularly referred to as Medicare.

Other subjects and speakers included: "What Medicare Means to Hospitals" by Marion J. Foster, Raleigh, Executive Secretary, N. C. Hospital Association; "What Medicare Means to the Practice of Medicine" by Edgar T. Beddingfield, M.D., Stantonsburg; and "What Medicare Means to Nursing Homes" by Travis Tomlinson, Raleigh, N. C. Association of Nursing Homes, Inc.

"Visiting in North Carolina Hospitals," the result of a recent study, was considered at the luncheon session by James P. Harkness, Ph.D., N. C. Memorial Hospital.

During the afternon session, rehabilitation was the theme for two addresses by Robert A. Gregg, M.D., Duke University, Durham, and Robert A. Lassiter, Raleigh, Director of the Division of Vocational Rehabilitation, Department of Public Instruction.

NEWS NOTE

Drs. Richard G. Lester and John T. Baggerly of Durham spoke to the annual meeting of the Radiological Society of North America, November 29-December 3 in Chicago. The topic was "Utilization of Image Intensification and 90 mm Photoradiography in Diagnostic Application."

JOHN AND MARY R. MARKLE FOUNDATION

The need for all educational agencies to establish headquarters in Washington is questioned by John M. Russell, president, in the annual report of the John and Mary R. Markle Foundation issued recently. "Washington has become a city with a glitter and glamour beyond compare for those seeking funds in support of education and research, especially in the health field."

"Granted that all things educational, scientific and medical now tend to be oriented toward Washington, we fail to see why every scientific and educational agency need head for the bright lights of Washington, like moths to the flame (and perhaps with the same tragic consequences!)."

Medical education is the chief interest of the Markle Foundation, which appropriated \$1,519,000 for the purpose during the year to medical schools. The report expresses concern that the national association of medical schools, the Association of American Medical Colleges, may move its headquarters to Washington.

Grants made during the year 1964-1965 include \$100,000 to Duke University School of Medicine



approximating the diuretic efficacy of meralluride

METAHYDRIN°

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., et al: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.



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Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

for construction of teaching facilities, and \$75,000 to the University of North Carolina School of Medicine for a medical curriculum study; \$30,000 to Western Reserve University School of Medicine for a cooperative experiment in medical teaching; \$15,000 to The University of Chicago Division of the Biological Sciences for a conference on preparation for the study of medicine; and \$25,000 to the University of Minnesota College of Medical Sciences for the medical library.

NORTH CAROLINA COMMITTEE ON NURSING AND PATIENT CARE

The North Carolina Committee on Nursing and Patient Care has obtained an excellent film dealing with the anxieties and frustrations of a hospital patient for showing to nurses and other hospital personnel responsible for patient care.

The film, entitled "Mrs. Reynolds Needs a Nurse," was donated by Smith, Kline and French Laboratories. It will be made available for showings through the Film Service of the North Carolina State Board of Health.

"Mrs. Reynolds Needs a Nurse" is a 38-minute black and white 16 mm. sound film.

FIFTY YEAR CLUB OF AMERICAN MEDICINE

Invitations are currently being sent to eligible physicians to join the Fifty Year Club of American Medicine.

Dr. Walter C. Alvarez, past president of the organization, says: "It is a great pleasure to have something to do with gathering together physicians in the United States who have practiced 50 years or more. It is hoped this club will carry on for many years."

An initiation fee of \$5 is required to pay the cost of a lapel button, a merit certificate suitable for framing, and a tie clasp.

Applications for membership should be sent to the secretary, Dr. J. H. McCurry, Cash, Arkansas 72421.

The next meeting and luncheon of the organization, scheduled to coincide with the 1966 meeting of the American Medical Association, will be held in Chicago next June.

AMA ENVIRONMENTAL HEALTH CONGRESS

Has man designed accidents into his environment? If so, what can he do about it?

These and other questions will be discussed at the American Medical Association's Third Congress on Environmental Health Problems April 4-5 at the Drake Hotel, Chicago.

Keynoted on the theme, "Accidents—A Preventable Epidemic," the Congress will include four panel workshops.

The first will be primarily concerned with the influence of environmental factors on the inci-

dence and types of accidents. The second will deal with some of the more important specifics of handling and treating accident cases including types of vehicular injuries, accidents of children and the aged, handling secondary complications, accidental poisonings, and recreational accidents. Panel three will focus on legislation, education, engineering and architectural design as a means of lessening accidents and their severity.

Panel four will be concerned with accident research and the need for more representative statistical data, better reporting, and improved research design.

For registration information, write EHC, Department of Environmental Health, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

DEAFNESS AND RESEARCH FOUNDATION

Now people with ear disorders can help give the priceless gift of hearing to those in future generations who might otherwise face a lifetime of deafness.

Through the Temporal Bone Banks Program for Ear Research, sponsored by The Deafness Research Foundation in cooperation with the American Academy of Ophthalmology and Otolaryngology, doctors believe the gift of hearing will be made possible to many in the future.

Unlike eye banks and other "banks" where healthy parts of the body are stored and later transplanted to the living, Temporal Bone Banks are laboratories where bequeathed inner ear structures are studied along with the donor's medical and hearing records. By this means it is possible for scientists to shed light on many of the mysteries of the inner ear. They are also able to relate a person's lifetime ear disturbance to specific ear disorders.

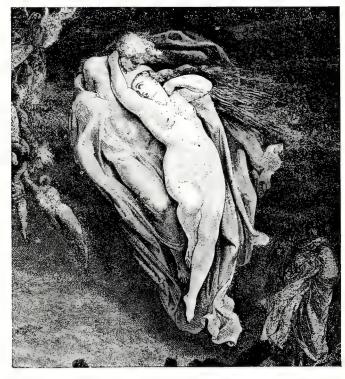
The Temporal Bone Banks Program has the full support of the leading medical associations in the field of otology, as well as that of the various national agencies which serve the deaf and the hard of hearing.

Pledge forms and detailed information about the program may be obtained by writing to The Deafness Research Foundation, Box 5000, New York, N. Y. 10017.

AMERICAN ASSOCIATION FOR THE HISTORY OF MEDICINE William Osler Student Essay Contest

THE WILLIAM OSLER MEDAL of the American Association for the History of Medicine is awarded for the best unpublished essay on a medico-historical subject written by a student in one of the medical schools in the United States or Canada. All students who are candidates for the M.D. degree, or who graduated in 1965, are eligible. This medal, first awarded in 1942, commemorates the

a rapid lift from the hell of depression



often relieves mental pain in 2-5 days

Doré Illustration from Dante's Inferno

NORPRAMIN® (desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety secondary to depression is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./daytwo 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.



LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind-neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may

include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000. great physician, Sir William Osler, who stimulated an interest in the humanities among students and physicians alike.

Essays should demonstrate either original research or an unusual appreciation and understanding of a medico-historical problem. Maximum length is 10,000 words. The prize-winning essay will be submitted to the Editorial Committee of the Association, which may recommend it for publication in the Bulletin of the History of Medicine.

Essays must be submitted by March 23, 1966, to the Chairman of the Osler Medal Committee, William K. Beatty, Librarian and Professor of Medical Bibliography, Northwestern University Medical School, 303 East Chicago Avenue, Chicago, Illinois 60611.

NATIONAL INSTITUTES OF HEALTH

The importance of an annual examination for cancer of the prostate gland in men over 40 is stressed in a new pamphlet issued recently by the National Cancer Institute of the National Institutes of Health, Public Health Service, U. S. Department of Health, Education, and Welfare.

The pamphlet, "Cancer of the Prostate," is the ninth in a series of ten prepared for the general public on cancer of different body sites.

Other pamphlets in the NCI series deal with cancer of the breast, uterus, skin, bone, lung, stomach, larynx, and colon and rectum. They discuss symptoms, diagnosis, treatment, related conditions, research, and the nature of cancer.

Single copies of "Cancer of the Prostate" (PHS Publication No. 1352) are available without charge from the Public Health Service, Washington, D. C. 20201. The pamphlet may be bought in quantity from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402, at five cents a copy or \$2.75 per 100 copies.

PUBLIC HEALTH SERVICE

The second national conference on community pesticides studies sponsored by the Public Health Service's Office of Pesticides is viewed by officials as laying a "solid basis" for increasing the pace and sophistication of the first in-depth medical research on relationships between pesticides and long-term human health hazards.

This stands out as the principal accomplishment of the three-day meeting held at Denver, Colorado, in November, according to officials of the Office of Pesticides which is supporting the community research.

"Many of the projects have been under way less than a year and are approaching the stage when research effort and skills can be focused on the production of concrete results," said Dr. Robert W. Weigher, Chief of the Office of Pesticides. "A solid basis for full-scale operations was laid by the conference program of scientific presentations and discussions by research contractor representatives from state and local health departments and academic institutions."

The conference specifically focused the attention of community researchers on approaches to epidemiologic phases of their studies and on problems developing leads to possible long-term pesticide health effects from short-term effect data. Shortterm, or acute, pesticide health effects are well known in comparison with the general lack of information on long-term, or chronic, effects.

The Public Health Service has issued its annual reminder that for entry or reentry into the United States, a valid certificate of vaccination against smallpox is required. Dr. Louis Jacobs, Chief, Division of Foreign Quarantine, said, "We urge all international travelers to arrange for vaccinations as soon as their plans are made, because vaccinations do not provide immunity until several days after they are received."

All travelers who enter the U.S., including Americans returning to this country, are required to have a valid certificate of vaccination against smallpox. The vaccination certificate becomes valid eight days after successful vaccination, or on date of revaccination, and is valid for three years.

Vaccinations should be recorded on an International Certificates of Vaccination document which can be presented to public health quarantine officials here and abroad. To be accepted for international travel, vaccination certificates must be validated with the stamp of the local or state health officer of the area in which the immunizing physician practices.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION

The Pharmaceutical Manufacturers Association (PMA) has announced that it has established a Foundation to promote the public health through scientific and medical research.

PMA's board of directors approved by-laws setting up the Pharmaceutical Manufacturers Association Foundation, Inc. (PMAF).

It has three main purposes. They are to:

- -Plan and initiate scientific and medical research activities.
- -Collect and disseminate to the public results of these activities.
- -Provide financial aid to selected individuals or educational institutions, or corporations' trust funds, or foundations whose purposes are scientific, educational or charitable.

PMAF will be governed by a seven-man board of directors chosen from PMA's 29-member board. Foundation headquarters are in PMA's Washington offices. Its president and chief executive officer is Dr. Austin Smith, PMA president.

As an example of the type work the foundation might sponsor, Dr. Smith mentioned that it could take over the administration of color additive tests begun three years ago and supported by some 30 PMA member firms. Also to be considered as a possible foundation activity is the joint sponsorship with the American Medical Association and the Food and Drug Administration of the new Registry for Tissue Reaction to Drugs recently established at the Armed Forces Institute of Pathology.

Medical Manuscript Editing Service

For more than ten years, the American Medical Writers' Association has provided a Medical Manuscript Editing Service. This service has been rendered by a Life Member of the A.M.W.A., Leslie L. Lewis, editorial director of a Mid-West publishing company. Headquarters of the Service are at the Ravenswood Hospital in Chicago.

The Medical Manuscript Editing Service is available to both members and non-members of the Association. The charge to members is \$5 for the first 1,000 words plus \$5 for each additional thousand or fraction thereof. The charge to non-members is \$7.50 for the first 1,000 words plus \$7.50 for each additional thousand or fraction.

Only manuscripts that are intended for medical journals or kindred publications, from which the authors receive no fees, and not exceeding 5,000 words in length will be accepted for review and editing.

On the manuscript itself, the Editor corrects punctuation; capitalization; spelling; misused words, including medical terms; and arrangement of bibliography. In addition, the Editor offers a line-by-line criticism of the manuscript covering such points as title, organization, tables and illustrations, sub-heads and summary, as well as grammar, syntax and usage.

Manuscripts must be sent by first class mail, typewritten, in English, double or triple space, with wide margins at top, bottom, and both sides, written on one side only, and accompanied by return first class postage. It is preferred that manuscripts be mailed flat; the number of words in the manuscript must be stated in the upper right hand corner of the first page; and the fee for the Service, including return postage, enclosed. The author should be sure to retain a copy of his paper. All manuscripts should be sent to the American Medical Writers' Association, Medical Manuscript Editing Service, Ravenswood Hospital, Chicago, Illinois 60640.

The Month In Washington

More and farther-reaching health legislation was enacted into law last year than ever was acted upon by a previous Congress.

Medicare and the heart disease, cancer, and stroke programs topped the list of such legislation enacted into law, but there also were other important new health programs authorized. Several existing ones were expanded.

Approved health legislation included:

- —A \$787 million aid program for medical, pharmaceutical and other health schools. It authorized for the first time federal scholarships for students and operating funds for medical schools.
- —A \$105 million program of aid for medical libraries.
- —A \$250 million, three-year extension of grants for construction of health research facilities.
- —Authorization of strict federal controls on manufacture and sale of barbiturates and amphetamines.
- —Requirement that cigarette packages, beginning Jan. 1, 1966, carry a health hazard warning.
- —Extension of the vaccination program and expansion of it to include measles.
- —Annual appropriation of a record \$1.2 billion for the National Institutes of Health.
- —Three new assistant secretaries of Health, Education and Welfare—one for health affairs.
- —A four-year \$92.5 million program of aid to municipalities for construction of garbage disposal plants and research in the field.
- —Greater federal powers in the water pollution field and \$300 million to help communities build sewage plants.
- —New federal powers to control air pollution, including requirement that new autos have devices to reduce exhaust fumes.
- —Expansion of the federal vocational rehabilitation program, including \$300 million in grants for building and initial staffing of rehabilitation facilities and workshops.
- —A four-year, \$173 million program for initial staffing of community health centers.

Turn a bundle of colic

into a bundle of joy







Colic, often in part a reflection of family tension, adds sleepless nights to patients' and parents' distraught days. Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying, improves feeding patterns ... permits sleep and rest ... for patient and family.

Pleasant tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be administered by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. Contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

PEDIATRIC PIPTAL° WITH PHENOBARBITAL

each cc. contains: 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal[®] (pipenzolate bromide), and 20% alcohol in a pleasant-tasting solution.





Prompt relief of pain and spasm in functional g.i. distress...

IPTAL* (pipenzolate bromide) efficiently suppresses acid secretion and motility ... relieves pain and spasm of peptic ulcer. Despite its potent gastrointestinal effects, "its clinically effective therapeutic dose is well below that required to produce side reactions." Because urinary retention is rarely a problem, PIPTAL (pipenzolate bromide) is "a highly desirable drug in the treatment of peptic ulcer in older patients ..."2 Tolerance to PIPTAL (pipenzolate bromide) has not been demonstrated, and the drug may be administered over prolonged periods without loss of efficacy. PIPTAL-PHB is specifically designed for the tense ulcer patient who will benefit from the sedative effect of phenobarbital.

1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. 8:73-77 (Jan.) 1957

2-Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

gastric ulcer

PIPTAL® - PHB

(phenobarbital, 16 mg., pipenzolate bromide, 5 mg.)

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(pipenzolate bromide)

IN BRIEF: PIPTAL—Each tablet contains 5 mg. pipenzolate bromide, PIPTAL-PHB—Each tablet (or 5 cc. of elixir) contains phenobarbital (warning: may be habit forming) 16.0 mg., Piptal (pipenzolate bromide) 5 mg. The elixir contains alcohol 20%. Side Effects: Dry mouth, blurring of vision or drowsiness may occur.

Contraindications: Withhold in glaucoma, bladder or g.i. obstruction, cardiac arrhythmias and in sensitivity to anticholinergies or phenobarbital (Piptal-PHB). Caution should be observed in patients with prostatic hypertrophy.

Administration and Dosage: PIPTAL or PIPTAL-PHB Tablets: One tablet three times a day before meals and one or two tablets at bedtime. (PIPTAL-PHB Elixir: One teaspoonful three or four times daily for adults and children over six years of age.)

Supplied: PIPTAL (pipenzolate bromide) 5.0 mg. Tablets—bottles of 100. PIPTAL-PHB Tablets—bottles of 100. PIPTAL-PHB Elixir—bottles of 8 fluid ounces.



—An Administration on Aging in the Health, Education and Welfare Department.

—Appropriation of \$157 million for Project Headstart—nursery school training and medical examinations of pre-grammar school children from low-income families.

—A \$69 million hospital program for the Appalachia area.

—Automatic rank of lieutenant general or vice admiral for surgeons general of the army, navy and air force.

—Extension for three years of the program of grants for health services for domestic migrant agricultural workers.

—A one-year extension of program of grants for general health aid and for community health services.

* * *

Community vaccination programs against measles have been recommended by the Surgeon General's Advisory Committee on Immunization.

In extending the federal vaccination program for polio, diphtheria, tetanus and whooping cough, Congress this year expanded it to include measles.

The Committee said that measles is one of the most important causes of serious illness in children and recommended that continuing "maintenance" programs aimed at vaccinating children about one year of age be established in all communities.

* * *

The Public Health Service has expanded its "pap" test program with a goal of providing cervical cancer tests for most women who enter hospitals and many of those who see physicians for any reason.

A total of \$6 million has been allotted for the expanded nationwide campaign.

Grants will be made to hospitals, medical schools, state and local health departments and non-government health groups for training of technicians, post-residency training of physicians, purchase of laboratory equipment examination of hospital outpatients, and other such expenditures.

Since last March, the American Academy of General Practice has been implementing for the PHS an office cancer detection program. A PHS spokesman termed the program "most effective," although not costly.

The PHS said it expects to achieve its goal in hospital tests within the next five years, with the number of hospitals providing this service to all adult women patients increasing each year during this period.

Hospitals providing care for the poor and medically indigent will receive first consideration in the awarding of grants. These patients have not been tested usually for cervical cancer, the PHS said. PHS Surgeon General William H. Stewart said the new hospital-based screening program reaching high-risk, low-socioeconomic groups offered "a truly effective" means of fighting cancer through the "pap" test for early detection.

Although the "pap" test was developed more than 20 years ago, only 20 per cent of the nation's 62 million adult women had received the test last year, the PHS said.

* * *

After President Johnson named the National Advisory Council on Regional Medical programs to advise the government on programs authorized by the Heart Disease, Cancer and Stroke law, Dr. James Z. Appel, AMA President, expressed regret that "the AMA was not asked to submit any nominations to this important body."

"Frankly, we are disturbed that the PHS has taken this action in view of our known interest in this Act and the inclusion, before its enactment, of the 20 amendments we had proposed,' Appel said. "You may remember that one of the amendments incorporated into the final bill was our suggestion that the Advisory Council have final authority in approving or disapproving grant requests rather than only advisory authority as initially provided."

Nonetheless, Appel told the AMA House of Delegates in Philadelphia:

"If we provide effective leadership, and if the PHS cooperates, it may be that this law will permit the development of programs which will benefit the public and be acceptable to the profession. I cannot urge you strongly enough, therefore, to take steps now through appropriate state and local

IN MEMORIAM 55

society committees to meet with medical school deans, state health department directors, teaching hospital administrators, and department heads in an effort to establish jointly a series of programs under the Act that would be wholly beneficial."

Named to the Advisory Council:

Dr. Michael E. DeBakey, Houston, who headed the commission that recommended the program; Dr. John Willis Hurst, Atlanta, the President's heart specialist; Dr. George E. Moore, Buffalo, N. Y.; Dr. Clark M. Millikan, Mayo Clinic, Rochester, Minn.; Dr. Cornelius M. Traeger, New York, N. Y.; Dr. Leonidas H. Better, Chicago; Mary I. Bunting, President of Radcliffe College; Gordon Cumming, Sacramento, Calif.; Dr. Bruce Everist, Ruston, La.; Dr. William Peeples, Maryland Health Commissioner; Dr. Robert J. Slater, Burlington, Vt.; and Dr. James T. Howell, Detroit.

Surgeon General Stewart will be chairman.

Clinical testing of the experimental drug DMSO has been discontinued by voluntary agreement of the drug sponsors and the Food and Drug Administration. The action was prompted by reports of adverse effects on the eyes of laboratory animals. About 1,000 investigators had been testing the drug on thousands of human patients. Both the American Medical Association and FDA previously had warned that attempted self-medication with the material was dangerous.

New Film Explains Hospital Costs

A new motion picture, "The Cost of Hope," is now being distributed on behalf of the American Hospital Association and its fellow sponsors. Designed for viewing by community organizations, such as hospitals, clubs, church and industry groups, and professional societies, the film depicts in human terms some of the factors which in recent years have led to increased hospital costs while adding immeasurably to the efficacy of hospital care.

Three years of painstaking research and preparation went into the making of the film, which was shot on location at a large, community hospital in Hackensack, New Jersey. "The Cost of Hope" was made possible by a grant from Johnson & Johnson and was produced in cooperation with the

American Medical Association, the American College of Surgeons, the American Nurses' Association, and the National League for Nursing.

One-hundred prints of "The Cost of Hope" are ready for free loan to community groups on a "first-call, first-served" basis. Requests should be addressed to Association Films, Inc., 347 Madison Avenue, New York 10017.

In Memoriam

Daniel Franklin Milam, M.D., M.P.H. 1894-1965

The death of Dr. Daniel Frank Milam on April 6 ended a career in public health which covered more than forty years and three continents.

Dr. Milam was born in Leesburg, Florida, on May 12, 1894. After primary education in Kentucky and Florida, Dr. Milam attended Stetson and Vanderbilt Universities.

It was only after his service as an ensign in the Navy during World War I that Dr. Milam entered the field of medicine at the University of Chicago Medical School, receiving his M.D. degree in 1923. He received the Master of Public Health degree from Johns Hopkins University. He served his internship in 1922-24 and then went with the Rockefeller Foundation.

Service with the Foundation took Dr. Milam to Poland, Austria, Canada, Czechoslovakia, Lebanon, the Virgin Islands, the Philippine Islands, and many parts of the United States. Included in his tenure with the Foundation was service in North Carolina, assigned as a Consultant to the State Board of Health. He first came here in 1932 when he was instrumental in locating the first cases of Rocky Mountain Spotted Fever in this State. With the assistance of Dr. Joseph C. Knox, now a Wilmington pediatrician, he organized the Communicable Disease Program which later became the Division of Epidemiology. For six years, Dr. Milam made a study of the nutritional status of the Bynum (Chatham County) and certain other rural communities in North Carolina. These studies were conducted through the Research Departments of Duke University and the University of North Carolina.

During his twenty-five years of service, Dr. Milam pioneered in studies on human nutrition and related subjects.

After his retirement from the Rockefeller Foundation, he served as National Director of the Planned Parenthood Federation for two years (1948-50). In 1950, he became Medical Director of the New York Heart Association, a position he held until 1959.

He then returned to North Carolina as Chief of

the Heart, Cancer and Chronic Disease Sections, where he served so ably until his death. During his administration of these responsibilities, the areas have progressed in an outstanding way in this State, matching progress in any other state in the Nation.

Dr. Milam was author of a score of articles in medical journals over the years of his service in public health. He was a fellow of the American Medical Association, of the American Public Health Association, and of the New York Academy of Medicine. He was licensed to practice medicine in Illinois, Florida, New York and North Carolina.

Dr. Milam married Mary Louise Wilson in 1924. They have four children—a daughter, Mrs. R. P. Creed, New York, N. Y.; and three sons, all of them medical doctors, Dr. John H. Milam, Winchester, Va.; Dr. D. F. Milam, Jr., Bellevue, Washington; and Dr. R. W. Milam, McAllen, Texas. Dr. Milam is also survived by two brothers, George W. and E. B. Milam, both of Jacksonville, Florida.

Because few men have had such long services in public health and few have served in so many areas of public health; because Dr. Milam was a versatile and dedicated public health physician and yet still had time to be a patient and kind person; because no one could have regarded him as anything but the fine gentleman he was; and because of the personal affection he generated and deserved and his devotion as a public health worker, he will be missed. Therefore, be it

Resolved, that this expression of respect and appreciation be formally enacted by the State Board of Health and spread upon its official minutes, and that a copy be forwarded to the family of our departed friend to convey, though inadequately, the heartfelt sympathy of the members of the State Board, and be it further

Resolved, that copies be also sent to the NORTH CAROLINA MEDICAL JOURNAL; Journal of the American Medical Association; the Journal of the American Public Health Association; the Medical Society of the State of North Carolina; the North Carolina Public Health Association; the Rockefeller Foundation; and the other organizations with which he was associated.

Classified Advertisements

Wilmington, North Carolina, James Walker Hospital. Starting 24 hour emergency room coverage. Yearly guarantee, regular hours. Write H. D. Pickard, M.D., for information.

YOUNG GP needs Partner NOW! Large practice and 12-room clinic. Start \$15,000 and work to equal partner 3-4 years. Piedmont N. C. beside lake and 18-hole course. Call me collect. R. V. Liles, Jr., M.D., Telephone 474-3390, Box 676, Norwood, N. C.

GOOD, SOLID general practice for sale in suburban area, Piedmont North Carolina. Hospital with GP privileges and most specialties nearby. Office extremely well equipped and designed. Practice plenty busy but not overwhelming. Golf, boating, hunting, fishing within 15 minutes. Excellent schools. Leaving for salaried position. Will introduce to patients and associates. Details on request. Reply Box 790, N. C. Medical Journal.

LOCUM TENENS WANTED for September, 1966, for a general practice in the mountains of Western North Carolina. Reply JOURNAL, Box 790, Raleigh, N. C.

PHYSICIAN WANTED - ADMINISTRATIVE MEDICINE—Veterans Administration Regional Office. Regular scheduled tour of duty. 40 hours per week. No OD Duty. Beginning Salary \$12,827. Excellent fringe benefits. Citizenship required. License in any state. Contact Personnel Officer, VA Regional Office, Winston-Salem, N. C.

WANTED: "General practitioner with a special interest in internal medicine, to be staff physician on a medical ward in a 390-bed GM&S VA Hospital in Fayetteville, N. C. Non-discrimination in employment. Address replies to Chief of Staff."



Supplement to

NORTH CAROLINA MEDICAL JOURNAL

January, 1966



TRANSACTIONS

ONE HUNDRED ELEVENTH ANNUAL SESSION

of

The Medical Society of the State

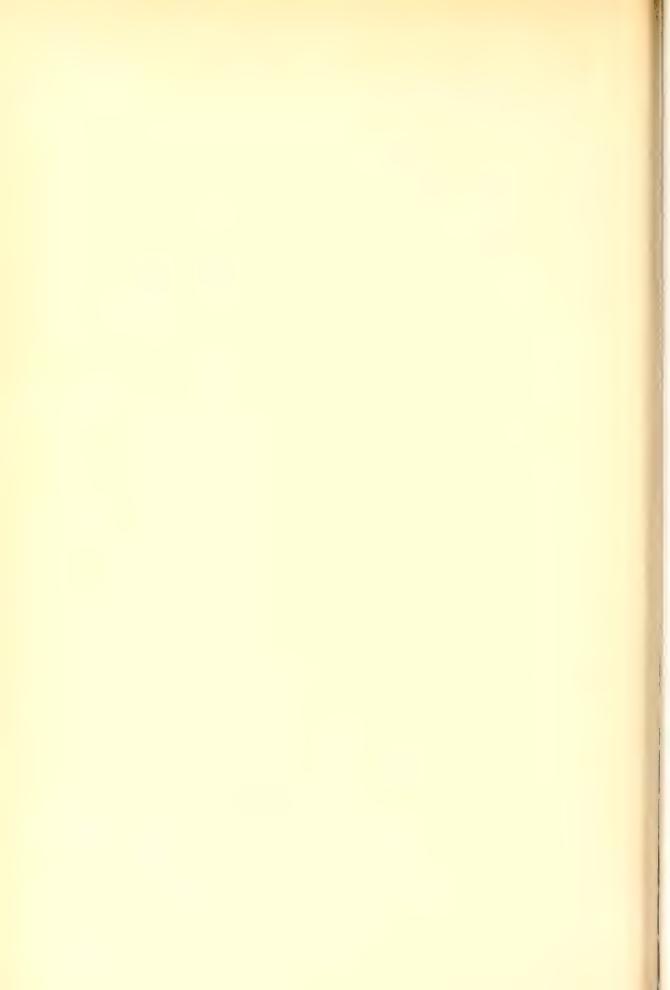
of North Carolina

held at

Charlotte, North Carolina

May 1-5, 1965

BRIEFED AND ABRIDGED BY JAMES T. BARNES, EXECUTIVE DIRECTOR 203 CAPITAL CLUB BUILDING, RALEIGH, N. C.



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Internal Medicine-Joseph B. Stevens, M.D., 1017 Prof. Village, Greensboro

Ophthalmology and Otolaryngology—WILLIAM R. HUDSON, M.D., Duke Medical Center, Durham

Surgery—Colin G. Thomas, M.D., N. C. Memorial Hospital, Chapel Hill Pediatrics—Lawrence E. Metcalf, M.D., 314 Doctors Building, Asheville Obstetrics and Gynecology—Louis S. Rathbun, M.D., 406 Flatiron Bldg., Asheville Public Health and Education—J. U. Weaver, M.D., P. O. Box 571, Henderson Neurology and Psychiatry—Robert N. Harper, M.D., 2109 Clark Ave., Raleigh Radiology—Everett H. Schultz, Jr., M.D., N. C. Memorial Hospital, Chapel Hill Pathology—Don S. Morris, M.D., Forsyth Memorial Hospital, Winston-Salem Anesthesiology—C. Max Drummond, M.D., N. C. Baptist Hospital, Winston-Salem Orthopaedics and Traumatology—Basil M. Boyd, Jr., M.D., 1822 Brunswick Avenue,

Student AMA Chapters-J. WILLIAM FUTREL, Duke U. Medical School, Durham

Charlotte

1965

TRANSACTIONS

OF THE

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

One Hundred Eleventh Annual Session

held at

Charlotte, North Carolina May 1 to 5, 1965

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COMPILATION of ANNUAL REPORTS

REPORT OF THE CONSTITUTIONAL SECRETARY

The enrolled membership in December, 1964, was 3,515. This represents an increase for the year of 81 members. The resume of the meetings at Pinehurst in September, 1964, and February, 1965, is recorded in the transactions.

The constitutional officers attended the annual meeting of the American Medical Association in San Francisco in June, and the president attended the interim meeting in Miami, 1964. The Association is deeply involved in the various legislative issues in regard to medical care for the aged under social security. This issue will have been voted on by the congress at the time of the annual meeting.

No significant changes have been made in the format for the annual meeting at Charlotte.

The interest, energy, and ability exerted by committee chairmen and committee members in the various assignments during the year is commendable. Summaries of their work are found in the transac-

The Headquarters office has continued to function well in a fiscally sound manner and continues to render outstanding service to the membership of the so iety.

Charles W. Styron, M. D. Secretary

REPORT OF THE EXECUTIVE DIRECTOR

Mr. Speaker, President Raiford, Members of the House of Delegates, distinguished guests, friends and Staff associates.

I here undertake to account for our stewardship of the "talents" for which we have been obligated-in-responsibility during this past year. As many of you know this constitutes the 18th annual accounting since the summer date in 1947 when a leadership group of this Society "found" me and, with some degree of intrepidity, embarked with me in the venture of exercising responsibility for a "few talents" which characterize the Society and your lay executive officer in those beginning days of concerted administrative efforts which did seem for the ultimate good of the medical profession in North Carolina. By degrees these passing years have become "golden years" in the "sunset" of a long career of service activity. May I claim that the satisfaction of the nearly two decades in your service have been wonderful, both for me and you, and that the records of this Society will show that there has been a steady progress in good activity and accomplishments through all these years. My tenets have been just so humble as that set out in a simple postal card of congratulations addressed to me by an honored friend and member of this Society in the early fall of 1947, when he said, "Iknow you will be a dutiful Secretary.

The problems are always the same and all will be

resolved." The sagacity of that message greatly impressed me then and despite the intervening time, the wear, and the intrigue which has transpired through all of our courses since then, I feel certain we can re-assert that philosophy today, live with it, and gain by it.

I must say we have had tremendous encouragement and much help from the Mecklenburg leadership in the preparation, planning, and staging of this 111th Annual Sessions of the Medical Society. Special tribute should be paid to Dr. Chalmers Carr and the members of his local Arrangements Committee who have worked diligently and understandingly in many of our accomplishments. It is to be hoped that the Society will formally recognize this very fine contribution during the course of deliberations here in Charlotte. All aspects of the Charlotte Community have worked unstintingly to make this Convention a success and the staff is deeply aware and appreciative of everyone's effort from the Convention Bureau's work on through all of the detailed arrangements of the owners of facilities and the multiple private services of this great community.

In reporting on the productivity of your staff this year I heartily pay tribute to the high level of leadership and guidance which President Ted Raiford has given to the Society, not only for the stimulation of the staff, but to the entire structure of the Society and its 3600 members. He has carried on his function unstintingly and with great intelligence and I know well that his sacrifice of time wisdom. and means has been a way-of-life during these past months, and you are indebted, as we are, to him for his marked accomplishments. It has been a good experience to have travelled the course with him and to have had the opportunity to help achieve so much in the wake of his fine leadership. It has been a blessing that his health has sustained him so effectively.

The membership must know to what unusual extent the business of the Society continues to grow -- the growth is worthy of your professional concepts and your means. Neither have been stinted. It is my sense that the image of medicine is reflected better - - witness the report of 'Opinion, Inc.' finding that the image is better than was so even a year ago. This, I think, is attributable to the great worth of the kind of medical care you render and to the infinite programs of activity in which you engage so generously for the public good. This is so despite the political expressions which increase month by month, it seems. Yet all pendulums swing and one may predict that if professional faith, professional worth and professional concern prevails people will not suffer so good a system of medical care to sink into oblivion - - where government now tends to drive it. So, I pray you will not lessen your loyal support for professional and public cause you know to be right. There is no evidence you will, and I'm sure that as individuals and as an organization your Society is at a high comparable level

and will go on to gain fuller statue and achievement. What you have - - what you have to give - - the purpose you serve are blessings to the people and your determination and your sacricicing support will surely prevail when you exemplify the continuation of this good thing in the world.

For the year President Raiford indicated a sound selection of committees and commissioners and the organization of these by headquarters went on at pace during late spring and summer, after which they have been active in producing the work of the Society. Problems of insurance and the aged, paramount for several years, have continued to involve the Society and during the year much consultation has resulted in progress on these two fronts. The Kerr-Mills MAA program required considerable effort on several committee fronts and has finally been implemented as to all uniformly available services state-wide, despite some political obstacles which have prevailed in this State and nation since it was authorized by the Congress in 1960. It appears to be working with good medical cooperation, much as we had predicted from the beginning, and is meeting the needs of the aged medically indigent. It is our hope that appropriations will be granted to properly support the program during 1965. On the insurance front progress has been made and now we sense that the problem of utilization is being confronted for the first time in a real way.

Throughout the year headquarters staff has been engaged in related educational matters anent the Medicare issue before Congress and in engaging in the Educational Campaigns on this subject designed by Surely this effort has yielded tremendous public understanding and expression of will, but the results seem deterred by the ever increasing political power which accrues to the National level. What the results finally will be may not be exactly predicted as this report is written, but a great deal of effort and substance has been devoted to education with effectiveness.

The Fall Conclave of Committees was a marked success and a great amount of policy was ferreted out for action by the Council and the House of Delegates. The Committee activity throughout the year has been marked and the accomplishments, we sense, are now being documented in the compilation of reports which will be under consideration by this session of the Society.

The Mid-Winter Public Relations Conference was well supported by the component societies and it, perhaps, was the strongest yet stated and well impells the Society in that field of activity. The expansion of the Conference into work-shop concerns on Friday evening was very productive and it is to be hoped that this emphasis on the practicable details of intersociety relationships and intra-activities can be continued in the future. The panel programs were strongly staffed and moderated with recognized success and the Committee on Public Relations and the staff are much encouraged that so much useful information was imparted and that we can move on to even stronger Conferences in the future.

Considerable progress has attended those Committees concerned with inter-professional relations.

On every front better understanding and cooperation has developed. We sense that this has encompassed the professions of dentistry, law, pharmacy, insurance industry, hospital administration, veternary medicine. fields of medical technology, and even nursing, where so much shortage prevails as to give great public concern for future advents. On the whole, this area of inter-professional relations, cited as strongly effected three years ago, has gone to greater heights of understanding and cooperation through the past year and bespeaks the strengths which can be attained at the professional level by working together. The staff continues to play an integral part in this useful endeavor and inter-staff relations have never been better, and where weakness does prevail we sense that the views of medicine are respected more and more because of the overriding public good inherent in these views and the actions which they motivate. It must be restated that inter-professional, interagency and inter-ancillary relations sometimes becomes the heart of medical progress and the medical profession augers well to give exercise to these areas of understanding and cooperation. Along with this we should constantly be aware of the import of standards and good ethics. These will stand us in good stead in the months and years ahead, as they always have.

In all these undertakings we at the staff level understand clearly our role by assignment and never in the role of creative policy. When we are studious, when we are alertive, when we have facilitated good faith and good will as conceived by the Society leadership we will have performed our best duty and wisely. As we have said before, "that has been our bidding and we desire that we be used more to coordinate thought, concern and design to the ways of evaluation and action for the greater good of the membership of the Society and the public which they serve."

STATISTICAL DATA

James T. Barnes, Executive Director April 1, 1964 to April 1, 1965

18,142
45,733
2,638
3,889
803
315
145
691
141
214

^{*}Does not include Public Relations Mail Dispatched

I herewith submit a report as Treasurer in the form of the annual Audit which has been reviewed and approved by the Finance Committee and the Executive Council. It reflects a successful fiscal activity and I recommend it to you for adoption along with this narrative report. I do assert that your financial affairs are in good order and the accounting is sound and in order.

Finally, I desire to express my appreciation to the officers, the committees and to the membership of the Society for the excellent directions we have during the year and for the confidences all have placed in us at the staff level during this good year of operation. Pray evaluate us always and help us to seek a better level of service to you and all who may be concerned with the productivity of our efforts. We sense we not only serve you but that we also serve great public causes in our State and our Nation. Thus we are thankful to the kind Providence which has supported and sustained us through the years and we invoke these blessings upon another year of effort at the threshold of its beginning.

Thank you.

James T.Barnes Executive Director Medical Society of the State of North Carolina

Raleigh, N.C., April 5, 1965

Attached herewith and filed with the official reporter is the original copy of the 1965 Audit Report of A. T. Allen & Company, Certified Public Accountants of Raleigh, North Carolina which bears the date of February 6, 1965.

AUDITOR'S REPORT MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED Raleigh, North Carolina 12 Months Ended December 31, 1964

OFFICERS

- Dr. Theodore S. Raiford President Asheville, N. C.
- Dr. George W. Paschal, Jr. . . . President-Elect Raleigh, N. C.
- Dr. John S. Rhodes Past President Raleigh, N. C.
- Dr. Hubert McN. Poteat, Jr. . First Vice President Smithfield, N. C.
- Dr. Wayne J. Benton Second Vice President Greensboro, N. C.
- Dr. Charles W. Styron Secretary Raleigh, N. C.
- Dr. John C. Reece Speaker of the House Morganton, N. C.
- Dr. D. E. Ward, Jr. . . Vice Speaker of the House Lumberton, N. C.
- Mr. James T. Barnes Executive Director Raleigh, N. C.

Chairman and Members of the Finance Committee Medical Society State of North Carolina, Inc. Raleigh, North Carolina Gentlemen:

Pursuant to engagement, we have audited the books and records of the Medical Sociaty State of North Carolina, Inc., Raleigh, North Carolina, for the period beginning January 1, 1964, and ending December 31, 1964, and present herewith our report.

Exhibits and Schedules

In presenting to you our findings, as the result of the audit, we have prepared four Exhibits and three Schedules, as outlined in the Index, which are attached hereto as a part of this report.

Balance Sheet - Exhibit "A"

The first statement is a list of the Assets, Liabilities, Reserves and Fund Balances, which we designate as Balance Sheet, December 31, 1964, Exhibit "A". This statement has been divided into two sections. One contains the Current Operating Fund, which represents the Current Assets, Liabilities, and Reserves. The other has been designated as a Capital or Non-Operating Fund containing the office equipment, real estate and capital stock owned and used by the Medical Society - at values established in a prior year plus actual cost for purchases during the last several years.

The cash on Hand and in Bank is made up of \$50.00 Petty Cash Fund and \$9,576.28 in the First Citizens Bank and Trust Company, Raleigh, North Carolina. The cash in Bank was verified through a reconciliation of the balances as shown by the records of the Medical Society with a certificate which was obtained independently from the bank. This reconciliation is shown in detail in Schedule 1 of this report.

Accounts Receivable - - Regular in the amount of \$10,071.66 are shown on the Balance Sheet. This amount includes \$7,057.87 advertising cost which was advanced for the American Medical Association and the balance represents the total of several uncollected balances due for local advertising in the State Medical Journal.

Accounts Receivable - National Advertising in the amount of \$4,898.99 represent November and December, 1964 National Advertising in the State Medical Journal. These amounts were confirmed directly with the State Medical Journal Advertising Bureau. The November amount was received in Jnauary 1965.

January 1965.

Prepaid Expenses and Supplies in the amount of \$414.36 represent Expenses paid prior to December 31, 1964, but applicable to the year 1965.

Ait Travel Deposit of \$425,00 is cash deposited with Eastern Airlines in order to secure air travel credit cards.

The investment in Investors Mutual, Inc., stock is shown at cost value of \$131,989.93. This represents the cost of 12,140.699 shares held December 31, 1964. During 1964 59.412 shares were purchased for \$747.40 which was received during the year as Unexpected Revenue from the Opthalmology and Oto-

laryngology Section of the Society. Also \$7,572.60 in dividends earned was reinvested in this stock. The value of this investment at December 31, 1964, was \$12.36 per share, or a total of \$150,059.04.

The real estate, capital stock and office equipment and furniture shown on the Balance Sheet in the amount of \$57,624.81 is listed in detail in Schedule 2. This represents an estimate made in a prior year which has been adjusted for purchases made during the last thirteen years. The items shown represent cost value of the equipment to the Medical Society as no depreciation has been recorded. As there are no liabilities outstanding against this equipment, we have shown the entire amount as Fund Balances -- Capital Fund - - in the Balance Sheet.

Under the "Liabilities" section we have listed those accounts, expenses, etc., incurred prior to December 31, 1964, for which statements or accounts were rendered or for which payment was due.

The Accounts Payable - Trade, in the amount of \$18,012.36 represents unpaid accounts at December 31, 1964. These were confirmed on a test basis with the creditors by the use of positive verifications. These unpaid accounts are for Journal and Roster publication, \$7,678.94; legal fees, \$7,000.00 and other expense, \$3,333.42. Most of these items were paid during the course of the audit.

The \$442.50, Dues to be Refunded, represents State dues collected which are refundable to the members. The \$27.50, Due American Medical Association, is 1965 A.M.A. dues collected in 1964. The \$405.00, "American Medical Association Dues in Escrow", represents dues paid to the State Society but which cannot be remitted to the National Society at the time due to diverse disqualifying reasons. The payroll taxes, \$137.21, for the Society's Social Security and \$1,183.26 for employee's Social Security and Withholding, were paid during the course of the audit.

The deferred credits of \$5,615.00 are for payments of \$3,815.00 received on technical exhibits space at the 1965 Convention, \$1,030.00 on 1965 Convention Banquet, and \$770.00 on 1965 membership dues. These remittances were received in 1964 and will be transferred to the income accounts during 1965.

The Reserve for Mental Hygiene of \$5,000.00 is a reserve to cover costs and expenses of the said committee in its rehabilitation work.

The Reserve for Raymond Randolph Scholarship of \$280.00 represents a reserve for the 1955 Essay Contest Winner, Raymond Randolph, Henderson, North Carolina. This amount is held in escrow for payment to the college of his choice, in accordance with the contest rules.

The Reserve for Medical Building Site represents the unexpended portion of the \$30,723.00 received from the sale of Series "F" Bonds. The expended portion of this fund is \$26,104.55 and is set out in Schedule 3 of this report. This leaves a balance of \$4,618.45 not disbursed to date.

The Fund Balance section of the Balance Sheet is comprised of two figures, \$121,704.94 being the balance of the Current Operating Fund for the year,

and \$57,624.81 representing the balance of the Capital Fund.

Statement of Fund Balances - - Exhibit "B"

The second statement is an analysis of the changes in Fund Balances during the year.

The Current Operating Fund Balance was arrived at by adding to the balance January 1, 1964, of \$95,639.12, the excess revenue over expenses of \$20,558.81 and the amount of dividends from investments used to purchase additional shares of \$7,572.60; subtracting the expenditures for Capital Fund, \$1,837.88, and adjustment for 1963 National Advertising, \$227.71, leaving a balance of \$121,704.94 at December 31, 1964.

The Capital Fund Balance increased during the year from \$56,454.23 to \$57,624.81. This increase represents the excess of purchases made during this period of\$1,837.88 from operating funds over the equipment traded on these purchases of \$667.30.

Statement of Income and Expenses - - Exhibit "C"

Astatement showing a budget comparison of the income and expenses for the twelve-months period is given in Exhibit "C". This statement is, in effect, a statement of operations for the year, and by examination it will be seen that the Income of \$247,453.31 exceeded the Expenses of \$228,732.38 by \$18,720.93. There was included in the expenses \$1,837.88 in Capital Expenditures for Equipment. Eliminating these we show income from operations of \$20.558.81.

In comparison with the budget, actual income was less than the Budget anticipated by \$3,526.69. The main items accounting for this are \$7,130.00 more from membership dues, \$1,338.09 more from Unexpected Revenue and \$1,244.61 more from Local Journal Advertising; \$9,013.00 less from National Journal Advertising, \$3,097.50 less from Sale of Ban quet tickets and \$1,552.50 less from sale of Exhibit space.

Further examination reveals that the total actual expenses were \$14,302.62 less than the budget provision. The Miscellaneous Budget had over-expenditures of \$1,909.59 while all other budget classifications show under-expenditures for the year.

Cash Receipts and Disbursements - - Exhibit "D"
Astatement showing in detail the cash receipts
and disbursements of the Society during the year under
review is shown in Exhibit "D" which we summarize
as follows:

Cash Balance January 1, 1964 \$ 8,245.62
Cash Receipts during the year 394,693.79
Total Cash Available \$402,939.41

Less - Disbursements during the year
For Operations \$251,867.85
To A. M. A. - Dues 138,860.00
For Capital Expenditures 1,837.88
Invested in Investors
Mutual, Inc., Stock 747.40 393,313.13

Cash Balance December 31, 1964 \$9,626,28

We made a careful analysis of the cash transactions and, where practicable, traced the receipts to their original source. Disbursements for expenses were supported by cancelled checks and invoices issued in the regular course of business. We believe the funds have all been accounted for.

General Comments

A surety bond covering faithful performance of James T. Barnes, Executive Director, in the amount of \$50,000.00, is in force, held by the Medical Society and was examined by us. We also examined and found in force a Primary Commercial Blanket Honesty Bond in the amount of \$25,000.00; a fire insurance policy - with 80% co-insurance clause - covering fire loss on office equipment, books and records in the office of the Executive Director, Raleigh, North Carolina, in the amount of \$20,000.00; an Automobile Schedule Policy; a Standard Workmen's Compensation and Employer's Liability Policy; and a Comprehensive General Liability Policy.

We were extended every courtesy and cooperation during the course of this audit and we experienced no trouble in obtaining the necessary information for this report. Scope of Examination and Opinion

We have examined the balance sheet of the Medical Society of the State of North Carolina, Incorporated, as of December 31, 1964, and the related statements of income and expense and fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of income and expense and fund balances present fairly the financial position of the Medical Society of the State of North Carolina, Incorporated, at December 31, 1964, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles for non-profit organizations applied on a basis consistant with that of the preceding year.

Very truly yours,
A. T. ALLEN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS
By: A. T. Allen
Certified Public Accountant
Raleigh, N.C., February 6, 1965

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Exhibits

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Statement of Fund Balances		
Statement of Income and Expenses	Exhibit	"C"
Cash Receipts and Disbursements	Exhibit	"D"

Schedules

Cash on	Hand and In Bank	Schedule 1
	of Capital Assets	
Schedule	of Building Site Costs	Schedule 3

(Exhibits and Schedules on following pages.)

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED Raleigh, North Carolina BALANCE SHEET December 31, 1964

December of, 1001		
ASSETS:		
Current Operating Fund: Cash on Hand and in Banks - (Schedule 1) Accounts Receivable - Regular	\$ 9,626.28 10,071.66	
Accounts Receivable - National Advertising	4,898.99	
Prepaid Expenses and Supplies	414.36	
Air Travel Deposit	425,00	
Investment in Investors Mutual, Inc., Stock	131,989.93	
Total: Current Operating Fund		\$157,426.22
Capital or Non-Operating Fund - (Schedule 2)		
Real Estate	\$ 26,104.55 31,320.26	
Office Furniture and Fixtures Capital Stock - Common - State Medical Journal Advertising Bureau		
Total Capital or Non-Operating Fund		57,624.81
TOTAL ASSETS		\$215,051.03
LIABILITIES, RESERVES AND FUND BALANCES:		
Liabilities:		
Accounts Payable - Trade	\$ 18,012.36	
Dues to be Refunded	442.50	
Due American Medical Association	27.50	
Due American Medical Association - Dues in escrow	405.00	
Federal and State Income Taxes Withheld Pay Roll Taxes Payable	1,183.26 137.21	
1 ay 1 and 1 ayable	137.21	
Total Liabilities		\$ 20,207.83
Deferred Credits:		
Advance Payment on Technical Exhibit Space at 1965 Convention	\$ 3,815.	00
Advance Payments On 1965 Convention Banquet	1,030.	
Advance Payments On 1965 Membership Dues	770.	00
TOTAL DEFERRED CREDITS		5,615.00
RESERVES:	\$ 5,000.0	0
Reserve for Mental Hygiene Committee Reserve for Raymond Randolph Scholarship Fund	280.0	
Reserve for Medical Building Site	4,618.0	
TOTAL RESERVES		9,898.45
FUND BALANCES:		
Current Operating Fund - (Exhibit "B") Capital Fund - (Exhibit "B")	\$121,704. 57,624.	
TOTAL FUND BALANCES		179,329.75
TOTAL LIABILITIES, RESERVES AND FUND BALANCES		\$215,051.03

57,624.81

\$179,329,75

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED
Raleigh, North Carolina
STATEMENT OF FUND BALANCES
December 31, 1964

CURRENT OPERATING FUND: \$ 95,639.12 Balance - January 1, 1964 ADD: Net Profit from Operations \$20,558.81 Increase in Investment - Dividends on Stock of Investors Mutual, Inc., Used to Purchase 28,131.41 7,572.60 Additional Shares \$123,770.53 TOTAL \$1,837.88 LESS: Expenditures for Capital Fund Adjustment to National Advertising Account for 1963 227.71 2,065.59 TOTAL CURRENT OPERATING FUND - TO EXHIBIT "A" \$121,704.94 CAPITAL FUND: \$ 56,454.23 Balance - January 1, 1964 1,837,88 ADD: Purchases made through Current Fund \$ 58,292.11 TOTAL LESS: Items Traded on New Assets 667,30

TOTAL CAPITAL FUND - TO EXHIBIT "A"

TOTAL FUND BALANCES - DECEMBER 31, 1964

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED Raleigh, North Carolina

STATEMENT OF INCOME AND EXPENSES

12 Months Ended December 31, 1964

	Budget Provisions	Actual	Difference Over Or (Under)
INCOME:			
Membership Dues - Current and Prior Years	\$179,880.00	\$187,010.00	\$ 7,130.00
Sales of Journal, Rosters and Value Scales	1,400.00	2,045.87	645.87
Author Contributions to Cuts	300.00	51.52	(248.48)
Revenue Unexpected	300.00	1,638.09	1,338.09
Sales of Technical Exhibit Space	21,000.00	19,447.50	(1,552.50)
Journal Advertising-Local Journal Advertising-Local	8,000.00	9,244.65	1,244.65
Commission (1%) From AMA For Dues Collected	32,000.00	22,987.00	(9,013.00)
Ticket Sales - 1964 Convention Banquet	1,350.00 6,750.00	1,376.18 3,652.50	26,18 (3,097,50)
TOTAL INCOME	\$250,980.00	\$247,453.31	\$ (3,526,69)
EXPENSES;			
Executive Budget;			
A-1 Expense - President	\$ 5,000.00	\$ 5,783.91	\$ 783.91
A-3 Travel - Secretary	1,000.00	757.17	(242.83)
A-4 Salary - Executive Director	16,000.00	16,000.00	-0-
A-5 Travel - Executive Director	5,000.00	5,000.00	-0-
A-6 Clerical Assistants - Office	33,500.00	29,732,57	(3,767.43
A-7 Equipment - Office	1,000.00	1,016.22	16.22
A-8 Expenses - Office	10,800.00	12,883,11	2,083.11
A-9 Bonding	-0-	-0-	-0-
A-10 Auditing	700.00	657.50	(42.50)
A-11 Payroll Taxes	1,278.00	1,497.87	219.87
A2 Insurance	230.00	242,68	12.68
A-13 Membership Record System	100.00	0-	100.00
A-14 Publications, Reports and Executive Aids	200.00	146.81	(53,19)
A-15 Insurable; Interest Insurance and			
Retirement Plan	1,371.00	1,135.68	(235.32)
A-16 Salary - Assistant Executive	10 500 00		
Secretary	10,500.00	10,500.00	-0-
A-17 Salary - Rural Health Consultant A-18 Travel - Assistant Executive	5,300.00	5,300.00	-0-
Secretary	1,800.00	1,850.47	50.47
A-19 Travel - Rural Health Consultant	2,000.00	1,752.55	(247,45)
Total Executive Budget	\$ 95,779.00	\$ 94,256.54	\$ (1,522.46)
Journal Budget:	e an 000 00	e ec ecc 17	\$/9 700 92
B-1 Publication of Journal	\$ 39,000.00	\$ 36,200.17	\$(2, 799 . 83 (348 . 71)
B-2 Cuts for Journal	700.00	351 . 29 2,310 . 00	+ O=
B-3 Salary - Editor	2,310.00 4,320.00	4,320.00	-0-
B-4 Salary - Assistant Editor B-5 Expenses - Editotial Office	450.00	371.63	(72.37)
B-5 Expenses - Editotial Office B-6 Expenses - Business Manager's Office	450.00	659.47	209.47
B-7 Equipment - Business Manager's Office	100.00	105.00	5.00
B-8 Travel for Journal	200.00	-0-	(200.00
B-9 Payroll Taxes	241.00	240.34	(66)
B-10 Sales Tax on Journal and Roster Sale.		486.53	(13.47)
Forwarded:			

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED Raleigh, North Carolina

STATEMENT OF INCOME AND EXPENSES(Continued) 12 Months Ended December 31, 1964

B-11 Publication of Roster B-12 Expense - Executive Council Reports	4,000.00 9,000.00	5,132.14 10,181.00	1,132,14 1,181,00
Total Journal Budget	\$ 61,271.00	\$ 60,363.57	\$ (907.43)
Intra-Functional Activity Budget:			
C-1 Expenses - Executive Council	\$ 2,500.00	\$ 1,652.24	\$ (847.76)
C-2 Expenses - Legislative Committees	7,000.00	4,094.77	(2,905,23)
C-4 Expenses - Maternal Health Committee	3,600.00	3,600.00	-0-
C-7 Expenses - Scientific Exhibits	0,000,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Committee	825.00	555.77	(269,23)
C-8 Expenses - Mental Health Committee	500.00	151.75	(348,25)
C-9 Expenses - Grievances Committee	200.00	56,20	(143.80)
C-10 Expenses - Chronic Illness Committee	2,500.00	1,745.09	(754,91)
C-11 Expenses - Committees in General	3,000.00	3,231.65	231.65
C-11 Expenses - Committees in General C-13 Expenses - Occupational Health	0,000,00	0,201,00	201,00
Committee	200.00	-0-	(200.00)
	1,126,00	881.21	(244.79)
C-17 Expenses - Student AMA Committee	1,120,00	001,21	(244,13)
C-18 Expenses - Military and Emergency	E00.00	10.96	(490 74)
Medical Service Committee	500,00	10.26	(489,74)
C-19 Expenses - Industrial Commission	0	50.00	E0.00
Committee	-0-	50.00	50.00
C-20 Expenses - Constitution and By-Laws		•	0
Committee	-0-	0-	-0-
C-21 Expenses - Medical Legal Committee	100.00	-0-	(100,00)
C-22 Expenses - Traffic Safety Committee	100.00	-0-	(100.00)
C-23 Expenses - Venereal Disease Committee	150,00	-0-	(150,00)
C-24 Expenses - Anesthesia Study Committee	400.00	400.00	-0-
C-25 Expenses - Blue Shield Deputation to			
National Blue Shield	200.00	-0-	(200,00)
C-26 Expenses - Blue Shield Committee	250.00	-0-	(250.00)
C-27 Expenses - School Health Committee	500.00	207.88	(292.12)
C-28 Expenses - N. C. Board of Public			
Welfare Advisory Committee	150,00	4.51	(145.49)
C-29 Expenses - Post Graduate Medical			
Study Committee	-0-	3,23	3,23
C-30 Expenses - Insurance Industry Liaison			
Committee	500.00	34,32	(465,68)
C-31 Expenses - Rural Health Function	800,00	380.72	(419.28)
Total Intra-Functional Activity Budget	¢ 95 101 00	\$ 17.050.60	\$ (8,041.40)
Total Intra-Punctional Activity Budget	\$ 25,101.00	\$ 17,059.60	φ (0,041,40)
Extra Functional Activities Budget:			
D-1 Expenses - Delegates to AMA	\$ 3,449.00	\$ 3,729.28	\$ 280,28
D-2 Conference Dues	150.00	189.50	39,50
D-3 Woman's Auxiliary	2,500.00	2,065.64	(434.36)
D-0 Wollian S Musiliary			
Total Extra Functional Activities Budget	\$ 6,099.00	\$ 5,984.42	\$ (114.58)
Dublic Beletions Budget			
Public Relations Budget:			
E-3 Committee Chairman, Out of State	¢ 500.00	\$ 175.37	\$ (324.63)
Travel	\$ 500.00 750.00	716.66	(33,34)
E-5 Equipment		5,517.84	517.84
E-6 Expenses, Office	5,000.00		78.19
E-8 Publications and Executive Aids	100.00	178.19	(199.49)
E-9 Audio-Visual Depiction	300.00	100.51	162.84
E-10 Educational Distributions	500.00	662.84	
E-ll News and Press Releases	400.00	376.11	(23.89)
E-12 Public Relations Bulletin	2,500.00	2,399.88	(100,12)
Forwarded:			

\$ 20,558,81

NET PROFIT FROM OPERATIONS

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED Raleigh, North Carolina STATEMENT OF INCOME AND EXPENSES(Cont.) 12 Months Ended December 31, 1964 (100.00)100.00 200.00 E-13 State High School Science Fair Program (41.31)650,00 608.69 E-14 Exhibits and Displays (506.23)493.77 1,000,00 E-15 Annual Officers Conference -0--0--0-E-16 Physicians Press Award 348.34 (251.66)600.00 E-17 Public and Personified Activities -0--0--0-E-18 Collateral Public Relations \$ (821.80)\$ 12,500.00 \$ 11,678.20 Total Public Relations Budget Annual Sessions (110th) Convention Budget 86.16 1,700.00 \$ 1,786.16 F-1 Programs 4,944.54 444.54 4,500.00 F-2 Hotel and Auditorium Expense 104.25 (695.75)800,00 F-3 Expenses - Publicity Promotion 679.39 (220.61)900.00 F-4 Entertainment 1,754.40 2,500.00 (745.60)F-5 Orchestra and Floor Entertainment (175.47)824.53 1,000.00 F-6 Guest Speakers 544.00 (6.00)550,00 F-7 Banquet Speaker -0--0--0-F-8 Electric Amplification (1.411.31)6,000,00 4,588,69 F-9 Booth Installation and Supplies 677.46 (32.54)700.00 F-10 Projection Expense -0-(100.00)100.00 F-II Badges 1,343,41 143,41 1,200.00 F-12 Transactions Reporting Service (68.96)181.04 250.00 F-13 Rental - Extra Facilities 1,500,00 2,274,63 774.63 F-14 Exhibitors Entertainment 6,500.00 3,887.96 (2.612.04)F-15 Banquet Expense 105.00 (195.00)300.00 F-16 Police Security \$ (4,804,54) \$ 23,695,46 Total Annual Sessions (110th) Convention Budget \$ 28,500.00 Miscellaneous Budget: 6,000,00 G-1 Legal Counsel 7,436,13 \$ 1,436,13 1,700.00 1,476.10 G-2 Reporting (Executive Council, etc.) (223.90)52,35 (257.65)G-3 Fifty Year Club 310,00 G-4 Contingency and Emergency 1,200.00 1,292,43 92.43 4,217.29 G-5 Employees Retirement System 3,400.00 817.29 325.00 299.04 (25.96)G-6 Advalorem Taxes 350.00 200,00 G-7 Association of Professions Loan (150.00)G-8 N. C. Hospital Association Recruitment Program 500,00 500,00 -0-221,25 221.25 G=9Association of American Medical Colleges -0-\$ 13,785.00 \$ 15,694.59 1,909.59 Total Miscellaneous Budget TOTAL EXPENSES \$243,035.00 \$228,732,38 \$(14,302.62) SUMMARY TOTAL INCOME \$247,453.31 LESS: EXPENSES: \$ 94,256,54 Executive Budget Journal Budget 60,363.57 17,059.60 Intra-Functional Activity Budget 5,984.42 Extra Functional Activities Budget 11,678,20 Public Relations Budget Annual Sessions (110th) Convention Budget 23,695.46 15,694.59 Miscellaneous Budget 228,732.38 EXCESS OF INCOME OVER EXPENSES \$ 18,720,93 ADD: Capital Expenditures From Current Funds 1,837.88

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA, INCORPORATED

Raleigh, North Carolina CASH RECEIPTS AND DISBURSEMENTS

RECEIPTS:

12 Months Ended December 31, 1964

AND THE STATE OF THE ARTON		
CASH RECEIVED FROM REGULAR OPERATIONS:	3100 040 00	
Members' Dues - Current and Prior Years	\$186,040.00	
Medical Journal Advertising - Local	9,214.25	
Medical Journal Advertising - National	23,899.64	
Sale of Exhibit Space - 1964 Convention	15,962.50	
Sale of Exhibit Space - 1965 Convention	3,815.00	
Medical Journal Subscriptions and Sales Of	9 010 00	
Rosters and Value Scales	2,019.89	
Author's Contributions To Cost Of Cuts	7.05	
Commission (1%) From AMA For Collecting	1,339.22	
National Dues	1,488.00	
Unexpected Revenue	6,998.24	
Reimbursement For Items Paid By The Society	2,162.50	
Miscellaneous Refunds	2,102,00	0050 046 00
TOTAL CASH RECEIVED FROM REGULAR OPERATIONS	370	\$252,946.29
AMERICAN MEDICAL ASSOCIATION - REGULAR DUES COLLECTE	.D	137,510.00
AMERICAN MEDICAL ASSOCIATION - DUES PLACED IN ESCROW		447.50
RECEIPTS FROM 1964 CONVENTION BANQUET		2,760.00
RECEIPTS FOR 1965 CONVENTION BANQUET		1,030.00
MOMAL DECEMBED		\$304 603 70
TOTAL RECEIPTS		\$394,693.79
CASH BALANCES - January 1, 1964:		
First Citizens Bank & Trust Co., Raleigh, N.C.	\$ 8,146,53	
Cash on Hand	99.09	8,245.62
Cash on hand	00.00	
TOTAL TO ACCOUNT FOR		\$402,939.41
		φ102,000.11
DISBURSEMENTS:		
DISBURSEMENTS FOR CURRENT OPERATIONS:		
Expenditures - Executive Budget	\$ 95,218.75	
Less: Capital Expenditures - Office Equipment	1,016.22	\$ 94,202.53
Expenditures - Journal Budget	\$ 63,561.32	
Less: Capital Expenditures - Office Equipment	105.00	63,456.32
Expenditures - Intra-Functional Activity Budget		21,278.21
Expenditures - Extra-Functional Activities Budget		6,495.73
Expenditures - Public Relations Budget	\$ 11,953.71	
Less: Capital Expenditures - Office Equipment	716.66	11,237.05
Expenditures - Annual Sessions (110th)		
Convention Budget		23,864.59
Expenditures - Miscellaneous Budget		18,804.19
Refunds Of Dues Over Collected		260.00
Refunds Of AMA Dues In Escrow		180.00
Refunds - Miscellaneous		3,581.00
Accrued Pay Roll Taxes - 12-31-63		1,374.05
Accrued Hospital Insurance - 12-31-63		71.60
Items Paid By The Society - Billed To Others		8,315.45
Total		\$253,120.72
LESS: Deductions from Wages - Unpaid at 12-31-64: Pay Roll Tax	xes	1,252.87
TOTAL DISBURSEMENTS - CURRENT OPERATIONS		\$251,867,85
PAYMENTS TO AMERICAN MEDICAL ASSOCIATION - REGULAR D	UES COLLECTED	138,860,00
EXPENDITURES FOR CAPITAL ASSETS		1,837.88
INVESTED IN INVESTORS MUTUAL, INC., STOCK		747.40
		2002 212 12
TOTAL DISBURSEMENTS		\$393,313.13
CASH BALANCES - DECEMBER 31, 1964:	0.00	
First Citizens Bank & Trust Co., Raleigh, N.C.	\$ 9,576.28	0.000.00
Cash on Hand	50.00	9,626.28
TOTAL ACCOUNTED FOR		\$402,939.41

			SCHEDULE	1	Bookcase	63.86
CASH	ON HAND AN	D IN BANK			Remington Rand Electric	215.01
D	ecember 31,	1964			Adding Machine Metal Storage Cabinet	78.28
	ANCES - DEC		. 1964:		Two Cabinet Shelves (Installed)	92.76 10.30
First C	itizens Bank	& Trust C	o., Raleigh, N.	C.	Metal Cash Box	2.32
	Per Bank Sta		\$ 13,928.		Pro Rata Share of Cost of Mimeograph Machine	337.47
ADD:			Ψ 10,520.	.11	Typewriter Table	21.00
Bank Er	ror in Charg	ing N. C. I	ntangibles		Metal Correspondence Separator Metal File and Sections	
Tax (Cha	rged 12-16-6	4; Correcte	ed 1-7-65) 81.	58	Two Typewriters—	
TOTAL			\$ 14,009.		Large Type (Bulletin) Kardex File and Parts Catalogue Case Metal File and Frames Secretarial Foot Control Three Transfer File Junior Pendaflex File Book Case Section	1.842.36
	standing Check	ke.	Ф 14,009.	09	Catalogue Case	20.00 93.07
	standing Check	V2:			Secretarial Foot Control	25.75
Number	0 5 00	10000	45.00		Junior Pendaflex File	16.23 22.87
10780	\$ 5.00	13220	45.00		Book case occiton	20,20
12258		13223	90.00		Swivel Chair and Arm Chair Audiograph Converter	74.48 28.84
	50,00	13224			Audiograph Converter Pendaflex File Wood Desk and Two Files	5.88
13151 13173	503.72 40.00	13225	298.32		Der Jur Camera with Flash Attachment and Case Audiograph Machine—Used Flight Bag Three Box Files Portable Lectern Metal File	201.93
	30.00	13227	30.00		Attachment and Case	300.00
13191	264.10		632.86		Flight Bag	38.31
13205 13214		13230	450.00		Three Box Files Portable Lectern	9 42
13214	112.50	13231	13.70		Metal File	114.33
13219	22.50	13232	300.00		Desk and Chair	101.48 268.45
13219	24,00	13233	13.83		Supply Cabinet Shelves	25.35
		13234	83.58 4,433.	41_	Portable Lectern Metal File Checkwriter — Paymaster Desk and Chair Supply Cabinet Shelves Pro Rata Share of Cost of Imperial Safe ED "60" (Karder)	
Balance	Per Books		\$ 9,576.	28	'Italdex'	290.00
PETTY CAS			50.0			1,621.00
					Five-Drawer Letter File and Frames	122.78
TOTAL CAS	SH - TO EXH	IBIT "A"	\$ 9,626.	28	Five Transfer Files	20.35
					Two Five-Drawer Filing Cabinets American Medical Dictionary	245.56 25.00
			SCHEDULE	2	Two Plate Glass Tops	
SCHEI	DULE OF CA	DITAL ACC	TO THE		for Desks Desk, Swivel Chair	20.34
oc ne			E 15		and Desk Set	253.87
	December 3	1, 1964			Remington Rand Electric Typewriter	430.59
OFFIC	E FURNITUE	RE AND FI	XTURES:		Electric Typewriter Pro Rata Share of Cost— Varityper — Used	
	cutive Office:				Pro Rata Share of Cost — A. B.	50.00
Wood	den File Case	Letter Size	e \$ 21.66		Dick Offset Duplicator Ten Pronto Files	1,602.27 46.87
Steel	writer Desk Office Safe		25.00 150.00		Two Four-Drawer Durable File Cabinets	
Steel	File Case—Le Steel Card	etter Size	20.00		One Kardex File Safe and Base	61.70 593.28
OIIIC	e Chair	ries	35.20		Pro Rata Portion of Postage Mailing Machine Pro Rata Portion of Robotyper	400.20
One Steel	Desk Filing Cabin	et.	62.55 24.50		Pro Rata Portion of Robotyper .	427.85 360.50
Offic	Filing Cabing to Desk File—Two File—Two File—Cabing Cabing Cabing Change	D	47.95		Pro Rata Portion of Perforator Pro Rata Portion of One Table	121.03
Steel	Filing Cabin	Drawer et	47.95 29.46 71.75		Pro Rata Portion of	18.47
					Postal Scale Stenorette Machine #215391	12.48 156.06
Offic	e Desk ee Equipment-	—Miscellaneo	87.29 ous 1.149.39		Stenarette Machine #210800	156.06
0110	Telephone T Pairs 12" x 3	able W Oode	en 15.45		Two Transcribing Kits for Stenorettes	60.08
V*e1	nts and Brack		8.77		Telephone Adapter and	
One Two	Desk Lamp Master Model	Audiograph	10.26		Switch Box Two Gray Legal Desk Trays	17.66 14.63
anc	il Attachments	2	795 67		Book Case Section #813 Walnut	29.26
Two	Map of Greate Double Files	er Carolinas	37.50 11.86		Gray Table #1808 Three Transcribing Kits	49.59
Tille	e rendamex				Three Transcribing Kits for Stenorettes Four Stetho Clips	89.75
Two	mes (Installed Gray Steel C	abinets	5.57 103.00		for Stenorettes	12.00
Three	e Transfer Fil Spec. B. Outfi	es	11.89		Documentor Electric Typewriter Remington Electric	372.55
Two	Legal Filing	Cabinets	7.25 19.90		Typewriter #E-2289256	360.21
One Plyw	Filing Shelf ood Carrying	Case	2.50		Pro Rata Portion of Used Addressograph Machine #312185	
for	Audiograph Framed	Case	17.00		with Work Table	75.00
Chart	ter Framed		3.61 2.57		Pro Rata Portion of Hand Truck Pro Rata Portion of Two	3.60
Cash	Box		2.79		Gingher Valets — #7-6-U	26.59
Three	Desk Desk Trays		158 98		Pro Rata Portion of Remington Electric Typewriter #2129420	153.83
wit!	h Stackers				Three Letter Size File Cabinets	103.72
Large	Chair Mat		9.27		One—TU-24 Stak Tube Roll File Pro Rata Portion of One	40.00
Glass	Desk Top . graph and Tr	inod	11.68		#11919 Paper Cutter . One—15 ft. x 16 ft. Rug and Mat	10.70 144.82
rour	Drawer Steel				Pro Rata Portion of Five Tables	27.78
Fili	ng Cabinet . Pendaflex Ste		78.03		One—122H Steel Cart with 3 Shelves	35.76
Fra	mes (Installed				One Brief Case	53.51
	l Scale pering Machine	e	6.50 14.88		Six Four-Drawer Letter Size Files One Documentor	199.31
	Stool				Electric Typewriter	372.55

				13
One Modern Tub Chair	31.82	Pro Rata Share of Cost		
Two Bookcases One Electric Projection Pointer	66.64 77.15	of Mimeograph Machine Pendaflex Frames (Installed)	$\frac{508.53}{4.64}$	
Two Side Arm Chairs, Walnut, Maroon Upholstery	77.62	Folder Machine and A. B. Dick Stand	397.88	
Two Side Chairs, Walnut, Maroon Upholstery	55.62	Used Elliott Addressograph Two Telephone List Finders .	$123.83 \\ 6.06$	
One Desk and Chair	44.81 149.81	Pendailex Frame (Installed)	4.50	
One Executive Swivel Chair,		Used Projector - Nedco Model DLS Screen	$153.43 \\ 32.45$	
wainut, Maroon Uphoistery	104.37 13.11	Record Player Microphone and Stand Projector with Case - Slide Lectern Mike	101.25 19.40	
One Walnut Credenza	125.30	Projector with Case - Slide	94.47	
Carpet Two Glass Desk Tops	63.95 22.45	Display Equipment - Flip Chart	56.85 31.74	
One Book Case (Used) Pro Bata Portion of One Toledo	15.45	One Camera and Flash Film Holders and Adapters	88.98 19.00	
Postage Scale (Used)	77:25		95.79	
Pro Rata Portion of One	137.61	Metal File Pro Rata Share of Cost - Varityper - Used	50.00	
Divisumma 24 Calculator Mirror—Secretary's Office	100.00 1.01	Pro Rata Share of Cost - A. B. Dick Offset Duplicator		
Portable Electric		Pro Rata Portion of	1,602.26	
Baseboard Heater Lamp for Conference Room	17.82 15.43	Postage Mailing Machine Pro Rata Portion of Robotyper	427.85 360.50	
Drapes and Rods for	114.75	Pro Rata Portion of Perforator Pro Rata Portion of One Table	121.02	
Walnut Dictionary Stand	67.07	Pro Rata Portion of One Table Pro Rata Portion of Postal Scale .	$17.58 \\ 12.47$	
Costumer Four Side Chairs	12.98 73.05	Stenorette Machine #205817 Pro Rata Portion of Used	205.06	
Four Side Chairs Stenorette Portable Dictating Machine and case #35077 \$	228.11	Addressograph Machine #312185	F F 00	
Pro Rata Portion of One		with Work Table Pro Rata Portion of Hand Truck	$\frac{75.00}{3.13}$	
Premier Ream Cutter Checkwriter — #XL4-076960	130.00 45.05	Pro Rata Portion of Two	8.83	
Pro Rata Portion of One Flex-O- Build Desk End File	38.15	Gingher Valets - #7-6-U Pro Rata Portion of One		
Pro Rata Portion of #1900		#11919 Paper Cutter Pro Rata Portion of Five Tables	10.70 27.78	
Addressograph #502 Sort-A-Tray Pro Rata Portion of Walnut	200.00 9.95	Two 4-Drawer Files Complete with Hanger Frames	194.47	
Pro Rata Portion of Walnut		Pro Rata Portion of One		
Step TablePro Rata Portion of	9.25	Toledo Postage Scale (Used) . One Underwood Scriptor Electric	77.25	
White Table Lamp Pro Rata Portion of Black Settee	4.10 31.08	Typewriter - #21-8721980 Pro Rata Portion of One	337.64	
Pro Rata Portion of Postal	16.13	Divisumma 24 Calculator	327.79	
Scale Rate Chart		Crestline DeLuxe Projector Pro Rata Portion of One	79.26	
Adding Machine Electric Fan #412 File Unit Pro Rata Portion of	18.49 19.45	Premier Ream Cutter Pro Rata Share of One	129.47	
#412 File Unit	15.72	Flex-O-Build Desk End File	13.00	
Verifax Copier	159.38	Scriptor Electric Typewriter S#8654172	300.00	
6-Tier File Pro Rata Portion of	8.72	Pro Rata Portion of		
	130.91	#1900 Addressograph Pro Rata Portion of Walnut	200.00	
Virco Desk	16.43	Step Table Pro Rata Portion of	9.24	
Pro Rata Portion of #4841 Thomas Collator	93.00	White Table Lamp Pro Rata Portion of Black Settee	4.09	
File Cabinet, 4-Drawer #24A	41.95	Pro Rata Portion of	30.67	
Remington Typewriter #3521299	388.90 388.90	Postal Scale Rate Chart Pro Rata Portion of Verifax Copier	16.13 159.38	
One Hand Truck Steel Shelving	13.59 123.60	Pro Rata Portion of		
Walnut Pamphlet Rack	7.00	4-Drawer Letter File Pro Rata Portion of	42.75	
Plastic Letter Tray Two Combination Desk Top Files	2.17 19.26	#7795 Virco Desk Pro Rata Portion of	15.00	
Stenograph Machine #645223 (Used)	100.00	#4841 Thomas Collator One Carri-Voice with Microphone	60.99	
One #5F Cosco		#444118 and One Revere Model		
Stenographic Chair	30.85	T-3000 Tape Recorder #3001312 Two 8B51 Gray File Cabinets	480,00 236-66	
TOTAL EXECUTIVE OFFICE	\$ 20,465.00	TOTAL PUBLIC RELATIONS OFFICE	\$ 8	3,411.45
PUBLIC RELATIONS OFFICE:		JOURNAL BUSINESS MANAGER'S OF		
Four Aluminum Desk Trays with Supports \$	9.00	Steel File and Frame \$	88.27	
Steel Costumer Cash Box	14.20 1.50	Pro Rata Share of Cost of Imperial Safe ED "60" (Kardex)	170.77	
Supply Cabinet Two Waste Baskets	37.00	Book - "Successful		
Two Waste Baskets	7.00 112.60	Sales Promotion" Pro Rata Portion of Remington	5.65	
Executive Chair Two Side Arm Chairs	48.80 60.40	Electric Typewriter #2129420 Pro Rata Portion of	153.83	
Metal Secretary Desk	136.40	Divisumma 24 Calculator Pro Rata Portion of	200.00	
Secretary Chair	30.20 37.00	#1900 Addressograph	100.00	
Two Chair Mats Ringe Top Card File	12.90 1.60	Pro Rata Portion of Verifax Copier	106.24	
Stapler	4.95	Stenorette Combination Unit	105.00	
Punch Metal Letter File with Lock	3.15 61.60	TOTAL JOURNAL BUSINESS		000 =-
Storage Cabinet Royal Typewriter	37.00	MANAGER'S OFFICE	\$	629 76
Two Electric Fans Four-Drawer Metal File	133.31 63.29	RURAL HEALTH AND MEDICAL CAR		TTEE:
Two-Drawer Metal File with	69.49	Masco Tape Recorder \$\ \text{One Desk}	185.40	
Lock and Base	18.36 75.00	One Steel File and Trays One Soundscriber	121.29 150.00	
Two Desk Trays and Stacks	4.64		200.00	
Metal Storage Cabinet	57.29	(Continued on Page 63)		

REPORT OF THE ASSISTANT EXECUTIVE DIRECTOR

Earnest effort in behalf of objectives charted by the Society Officials and your Executive Director has been my watchword during the period of this report. It is sincerely hoped that such effort has contributed materially to a continued development and productivity in the best interest of the State Medical Society.

Wise guidance by your Executive Director, Mr. James T. Barnes, has been willingly rendered by him in the proper overall coordination and direction of staff activities. This advice and guidance is particularly helpful and appreciated.

My sincere thanks also are due the Chairman of the Public Relations Commission, Dr. David G. Welton, under whose commission a number of projects have been undertaken with individual committees so assigned. Advice and counsel has also been willingly given by the Chairman of the Committee on Public Relations, Dr. Philip Naumoff, on the many occasions of Society matters being referred to him.

Considerable time and effort was spent during the fall weeks on a National Educational Program sponsored jointly by the State Society in cooperation with the American Medical Association and the County Medical Societies. This program was designed to provide information about Kerr-Mills and other programs providing health care for persons over 65 years of age and included educational advertising messages in all newspapers of the state. This was a joint undertaking of your Committee on Legislation and the Committee on Public Relations.

A renewed Educational Campaign of public information and Congressional action was undertaken by the State Society during March under the auspices of the Committee on Legislation in an effort to acquaint the public concerning the "Eldercare" proposal. Large quantities of literature were distributed and educational messages appeared in all North Carolina daily newspapers, and on radio and television. County Medical Societies were urged to supplement these mdia efforts locally and to mount an effective letter-to-Congressmen campaign.

All reports seem to indicate that the annual Conference of County Medical Society Officers and Committeemen, sponsored by the Committee on Public Relations, continues to be a valuable effort and beneficial service to the County Society officials in attendance. This year's conference was conducted on Saturday, February 6, 1965, and maintained a high standard of speaker participation. The necessary preparation and arrangements for the conference involved considerable time and effort, principally in the winter period just before the first of the year and during January and February up to the date of the meeting. A total of 165 persons attended the conference, with 100 of these being physician members.

The "Information Booklet for Physicians" developed approximately two years ago has been continued as a project for new members. The project has been expanded to include an Orientation Kit of materials for new members available from the State Society Headquarters Office through the respective County Medical Societies.

The Public Relations Bulletin has been edited on a basis of nine issues a year, published monthly except for May, July, and August. Efforts continue to make the Bulletin as newsworthy and brief as possible for expeditiously reaching the membership with messages and information of importance. The volume of requests for inclusion of material with the Bulletin is indicitative of its popularity as an effective means of reaching the Medical Society membership.

A two day Speech Training Session offered by the Smith Kline and French Laboratories was developed under sponsorship of the Committee on Public Relations and held in Durham on December 4-5, 1964. Limited to an enrollment of 25 physicians, the program was evaluated by the participants as very beneficial. It is anticipated that additional such training sessions may be arranged in the future for other areas of the state for the benefit of Society members.

Gift subscriptions to the AMA Magazine TODAY'S HEALTH are being renewed for members of the N. C. General Assembly, Governor, Council of State and Supreme and Superior Court Judges, as a project of the Committee on Public Relations. One subscription for each College Library is being added to the list for 1965.

The Insurance Industry Liaison Committee of the State Society continues its quarterly meetings with the Health Insurance Council and their joint undertaking known as the Claim Review Service (C.R.S.) These meetings have been attended and reported on in a staff capacity.

Assistance to the Committee Advisory to the N. C. Department of Motor Vehicles has been rendered where appropriate. The National Conference on Medical Aspects of Driver Licensing was attended in this capacity, held in Chicago, Ill., on November 15-18, 1964.

A State Fair exhibit was arranged and followed through to execution during the period October 12-17, 1964. An AMA display entitled "We Hear" was used in addition to the blood typing service offered in cooperation with the N. C. Association of Medical Technologists. The Wake County Auxiliary also graciously furnished assistance for the distribution of educational literature and registration of patrons of the blood typing service.

February 1965 marked the completion of a three year term as a member of the AMA Advisory Committee to the Director of the Communications Division. Quarterly attendance on this committee provided beneficial information and insight into programs of the AMA and activities of other state medical societies.

The Annual Committee Conclave heal September 23-26 was an intensive period of Committee meetings participated in with staff assignment to those Committees functioning under the Public Relations Commission. Preparation and coordination of publicity efforts on behalf of the Annual Sessions of the State Society have been continued each year, as well as, publicity and promotion of various other Society activities.

Under the leadership and sponsorship of the Committee on Child Health and Poliomyelitis North Carolina became one of the first, if not the first state, to complete a county-by-county Sabin Oral Poliomyelitis

Immunization campaign for each and every area of the state. Immunization figures are being compiled for a more complete report on this undertaking.

The two-day Annual Public Relations Institute of the AMA was attended in Chicago on August 20-21, 1964. Other conferences and meetings attended included: Special AMA Legislative Conference, Memphis, Tennessee on August 25, 1964; AMA Scientific Session, Miami Beach, Fla., November 28-December 2, 1964; Chamber of Commerce, Public Affairs Conference, Washington, D. C., February 3-4, 1965.

The staff of the Headquarters Office is always willing to undertake assistance to county medical societies wherever possible. To do so, however, we must first know about your needs. Many aids in the form of literature, films, etc. are available on request.

Constructive effort at the local level frequently generates understanding and support for the medical profession. One obvious answer to the need for such better understanding is for every practicing physician to devote some portion of his time to act as a spokesman for what is best in medicine. By wise participation in community or state activities, he can demonstrate by deeds and words what modern medicine under free enterprise can accomplish for all. If each doctor will contribute of his own good character and talents to help create better understanding of the profession, what changes could be wrought in the tremendous problems facing the membership.

As an indication of detailed effort statistical reference is made to the following tabulations with regard to the public relations mailings:

April 1, 1954 to April 1, 1965

April 1, 1004 to April 1, 1000	
Mail received Included in report of Executive	Director
Mail dispatched	_ 27,988
News Releases Mailed	_ 7,610
Public Relations Bulletins	30,230
Educational Pamphlets	_135,988
Films	_ 23
First Aid Charts	1,736
Miscellaneous	_ 61
Exhibits	_ 3
Telephone calls: Local	_ 1,031
Long Distance	_ 244
William N. Hilliard	

REPORT OF THE EDUCATION CONSULTANT

Assistant Executive Director

The services of the Education Consultant have been available to the committees of the Public Service Commission, the Rural Health Committee, and the Committee of Physicians on Nursing. Some of these duties have included (1) sending out notices of meetings (2) recording activities and recommendations of the committees (3) follow up on special projects, and (4) liaison with other related organizations.

Special projects will be reported in more detail.

The release by other groups and organizations of documents and reports pertaining to nursing and nurse education in North Carolina has required the Committee of Physicians on Nursing to meet many times.

The committee reviewed and made recommendations on the REPORT OF SURVEY OF NURSING EDUCATION IN NORTH CAROLINA by Ray E. Brown and GUIDELINES FOR NURSING EDUCATION IN NORTH CAROLINA developed by the Ad Hoc Committee of the State Nurses' Association and the N. C. League of Nursing. The Committee also considered the Re-draft of the Nurse Practice Act and communicated these suggestions to the N. C. Board of Nurse Registration and Nursing Education. Several meetings with the nurses, hospital administrators, and the N. C. Board of Higher Education were held.

The quarterly meetings of the N. C. Committee on Nursing and Patient Care have been attended.

The Committee on Mental Health and Medicine and Religion and its subcommittees on Physician Education, Public Education, Children's Services, Alcoholism, and Medicine and Religion promoted a very ambitious program this year. The Education Consultant met with the Program Committee to plan for a Leadership Conference for Physicians on New Approaches to Emotional Disorders, March 11, and 12, 1965, Sir Walter Hotel, Raleigh, N.C. The Conference was held in joint and simultaneous sessions with the Annual Meeting of the N. C. Mental Health Association.

The Subcommittee on Medicine and Religion has organized a speakers bureau on this topic. The Children's Services Report will be published jointly with the N. C. Mental Health Association. This report will be used later in the fall for the basis of a multidisciplinary conference.

A team composed of a psychiatrist as a resource person and a non-psychiatrist as a moderator is available to county societies for physician education in psychiatric skills.

Continued liaison with the Department on Mental Health and the N. C. Mental Health Council and its planning staff has been maintained.

The 11th Annual Conference of State Mental Health Representatives, March 4-6, 1965, Drake Hotel, Chicago, was attended by the Consultant. A brief presentation, at the request of AMA's Council on Mental Health, was made by the Consultant on the State Mental Health Committee's program and activities on "Effective Programming for County Committees." A summary of the Committee's work for the past two years was reported. Participants in the conference were particularly interested in the twenty-two page booklet, "Program Guide for County Medical Society Mental Health Committees," which the committee developed and sent to all county committee members.

The Committee on Rural Health has met with its Advisory Committee and held a joint meeting with the Rural Health Committee of the N. C. Academy of General Practice. The Consultant served as liasion person with rural organizations and groups including the Rural Safety Council, the Youth Power Program, the Farm Bureau, Area and Community Development, Extension, the Grange, and 4-H Clubs.

Copies of TODAY'S HEALTH were presented to the school libraries of 4-H Health Kings and Queens in their honor. The Committee sponsored the State

4-H Health Queen's trip to Chicago for the National meeting.

Request for pamphlets and materials on rural health by auxiliary county chairmen have been filled. The 17th National Conference on Rural Health sponsored by the Council on Rural Health of AMA was attended in Columbus, Ohio.

Efforts have continued to encourage county medical societies to consider homecare programs. Announcements through the P. R. Bulletin of the availability of the "SHOP TALK" on Home Care were made. The First National Conference on Homemakers Services was attended in Washington, D. C.

A calendar on state and national meetings in the area of chronic illness is kept and members of the committee notified. The Conference on Aging was attended in Ann Arbor, Michigan.

A joint letter with the N. C. Nursing Home Association was mailed to all nursing home owners in N. C., urging them to apply for accreditation to the National Council on Accreditation of Nursing Homes. Members of the Committee on Chronic Illness have been urged to contact nursing homes in their area and encourage them to apply for accreditation. Physicians in N. C. received a list of nursing homes in N. C., with the homes' classifications.

The Consultant also served as recording secretary to the Joint Committee on Health Care of the Chronically Ill and Aging.

The American Medical Association, Department of Community Health and Health Education, sponsored the First National Conference on Health Education Goals, October 30, and 31, 1964, Chicago, Illinois, which the Education Consultant attended along with the Executive Director. Emphasis at the conference was on significant factors in health education practice, for example, the motivation of people to put to use the information available on health. The problems involving communication and interpersonal relations was discussed.

The Sixth National Conference on the Medical Aspects of Sports sponsored by AMA was attended by the Consultant and the Consultant assisted in compilating the activities of the Committee on School Health for the "Survey Report of School Health Activities of State Medical Associations," Department of Community Health and Health Education, AMA.

Request for information and brochures on health careers have been followed up. Meetings of the N. C. Family Life Council, N. C. Conference for Social Service, and the N. C. Health Council have been attended. The N. C. Health Fair in Durham was attended.

The activities of the Education Consultant have been under the direction and guidance of the Executive Director with the cooperation of the Staff. Medical Society meetings of the Executive Council, Conclave, Officers's Conference, and Annual Meeting were attended.

Kay K. Zeigler Education Consultant REPORT OF THE PRESIDENT OF THE AUXILIARY
TO THE MEDICAL SOCIETY OF THE STATE OF
NORTH CAROLINA

1964-65

When I took the oath of office in May of 1964, I challenged each of you to improve the image of the doctors, individually and as a group, by reflection of your words and deeds. I challenged you to perform in a manner which would bring public understanding and approval. In return, I promised to lead you with the wisdom and dignity which would portray the doctor's wife as a woman of dedicated service. In my opinion, you have accepted that challenge and I have followed through on my promise to the best of my ability.

I have tried to keep you informed of my activities through the AUXILIARY NEWS, but in the event you have missed them, I shall state them here very briefly.

The summer months were spent in attendance at the AMA meeting in San Francisco and in editing the GUIDE POSTS, dedicated to you as the doctor's image; and to planning the Fall Board Meeting and Officers Conference. This meeting which was held on the Duke Campus, September 9, 1964 was designed to better inform the State Chairmen and the County Officers of their duties and responsibilities. At this time I also attended a two day regional meeting of the AMA-ERF Committee in Atlanta, Ga. which I felt to be very worthwhile and informative. Following this, I attended the three day Fall Conference for State Presidents and President-Elects in Chicago. I was privileged to serve on a reactor panel with three other State Presidents.

At the Fall Meeting of the Council of the Medical Society valuable advice was received from a meeting with the Committee Advisory to the Auxiliary and my plans for the year were outlined to the Executive Council of the Medical Society.

In February I attended the Conference of the County Medical Society Officers and Committeemen in Pinehurst and was honored to have been the luncheon speaker for that group. I was extremely pleased to see the attendance of so many Auxiliary members at this meeting, showing evidence of growing interest in the affairs of the Medical Society.

I have attended 6 District meetings and in those Districts which either did not hold a meeting or with which I had a conflict I have tried to attend county meetings. I have held Executive Committee meetings when necessary and have represented the Auxiliary whenever and wherever I have deemed it pertinent. I have worked closely with the Convention Committee, so capably chaired by Mrs. Ledyard DeCamp, and feel sure that this will be a banner convention.

My special thanks go to my officers and chairmen who have performed so untiringly this year. My special thanks go to the Councilors and county Presidents who have cooperated so willingly. Undying gratitude is extended to Dr. Theodore Raiford, President of the Medical Society, who has never been too busy to advise with me in matters relevant to the Auxiliary. I am also indebted to the Advisory Committee of the State Medical Society whose members, together with the co-chairmen, Dr. Roscoe McMillan and Dr. C.

Tolbert Wilkinson, have shown a real, honest interest in the operation of our Auxiliary. To Mr. Barnes, Mr. Hilliard, Miss Zeigler, Mrs. King, Mrs. Arrington, and other members of the Headquarters staff, my sincere appreciation for their cooperation.

And, now, to show you how our Auxiliary has met its challenge, I offer you the following report:

AMA-ERF Although all counties have not reported at this time, indications are that we will have a total increase in the amount contributed to AMA-ERF. Various methods have been employed in raising this money from budgeting to the sale of notepaper, playing cards, charms and an auction.

AUXILIARY NEWS Four issues have been mailed to the entire membership. The purpose of the NEWS is to keep you informed concerning Auxiliary affairs throughout the state. I would suggest that you use it to better advantage. The AUXILIARY NEWS is published by Hospital Savings Assoc, in Chapel Hill and mailed from the Headquarters of the State Medical Society.

 AWARDS . These awards will be made during the $\operatorname{Convention}_{\:\raisebox{1pt}{\text{\circle*{1.5}}}}$

BY-LAWS Since the By-laws were revised in 1963, it was necessary to make only one change. This was a clarification of the eligibility of a recipient of a Student Loan.

COMMUNITY SERVICE Thousands of hours have been spent during the past year in every phase of community service with Church work and health projects participation topping the list. One county contributed \$1500.00 for a room in the new wing of their county hospital. Many members are serving on various Boards, both locally and on a state level. One member is on a county Bi-racial committee and one member is on her county zoning committee. In almost every county there are active members of PTA groups, scouts, and volunteer care of mentally retarded children. One member is on a Citizens' Committee on Alcohol Education and one county is organizing a non-profit nursery for nurses, children in order to help ease the nurse shortage. We also have our share of local and state politicians.

DISASTER PREPAREDNESS Since professional personnel is operating this program in almost every area, our membership is cooperating to the extent that they are on record as being available should they be needed. Many members have taken courses in Medical Self Help, First Aid, and Home Nursing. They are continuing to keep informed through pamphlets and speakers. One county is organized to go to the hospital as a group in the event of a disaster.

DOCTOR'S DAY Many plans are being made to observe Doctor's Day in a variety of ways the last of March. This will be reported later.

HEALTH CAREERS Almost all counties in the state have participated in the field of Health Careers in

some manner. Many counties sponsor scholarships for nurses and other allied training. There are Health Careers days in the local schools with the formation of Health Career Clubs. Speakers, films, and literature are used in the schools and tours of medical facilities are sponsored. Auxiliary members have cooperated in the planning and assisting at the regional Health Careers Congresses. There are many Candy Stripe programs throughout the state. Alamance-Caswell's Antiques Fair has become famous.

HISTORIAN A detailed statistical summary of the activities of the year 1963-64 has been compiled to add to the reports of the preceding years.

INTERNATIONAL HEALTH ACTIVITIES Not half of our counties participate in this project, but those counties which do go all out in sending cartons of drugs, old instruments, textbooks, and bandages. Many foreign doctors and their families have been entertained in the homes of our Auxiliary members and Forsyth-Stokes invited all foreign doctor's wives to be guest at a luncheon in Winston-Salem.

LEGISLATION Auxiliary members actively participated in the 1964 elections in both major parties. We have many members of the League of Women Voters with some holding high office in their local organization. We have one member who was a representative to the National Democratic Convention. Letters, telegrams and personal contacts were made from throughout the state to our members in Congress against King-Anderson legislation. Operation Hometown was willingly put into effect when the call was made.

MEMBERSHIP As of February 18, 1965 the total membership was 2287 with 20 North Carolina Counties unorganized and 3 inactive. Eleven (11) Counties reported 100% membership with all eligible doctors' wives having paid dues. We have 8 members-at-large in unorganized counties and 15 Life Members.

MEMORIALS Tributes to deceased members and their families have been made throughout the year. A service for these departed members will be held on Sunday night prior to the opening of the convention. Three members have died during this year, as of February 20, 1965.

MENTAL HEALTH Operation "Santa Clause" and volunteer services top the list of participation in the field of Mental Health, although many of our members are on various Boards of organizations related to Mental Health. Films and speakers were used on a local level for program material.

MENTAL HEALTH R.E.F. This fund of voluntary contributions for psychiatric research and treatment at Memorial Hospital, University of North Carolina is increasing approximately \$1000.00 per year. Now 4 years old, the incomplete balance for February 1965 is \$6655.87.

PROGRAM, RADIO, T.V., MOVIES A wide variety of

program material was used this year. Auxiliaries used speakers on many subjects of interest to their membership. Films were used extensively, as were service programs such as making bandages while meeting. Halifax-Northamption is unique in that Mrs. Boone, with her own radio program, presents two or three medically related programs each week. What we would not give for more Mrs. Boones.

PRESS AND PUBLICITY An allied effort has been made to report those events and projects which reflects the Auxiliary as a service organization rather than a social club.

RESEARCH Twelve counties reported participating in a research project of some kind. Many of these are a continuation of medical biographies already is print. Two counties have started compiling histories of the doctors of their counties from 1800. Forsyth—Stokes has undertaken a mammouth job in collecting the biographies of the physicians of Old Salem, "Brethren with Stethoscope", which is to be published this spring along with the collection of medical artifacts for display in the Wachovia Museum. Their long range aim is to exhibit a 19th century doctor's office. A different kind of research project is the present day family type research presented by the Gaston County Auxiliary as their Christmas skit.

RURAL HEALTH Outstanding participation in Rural Health effort was made by Wake County and by Forsyth-Stokes. Auxiliary members from Wake County Auxiliary manned the Bloodtyping booth at the State Fair where a record number of 1216 persons were typed. Forsyth-Stokes set up and manned an educational booth on tetanus at the Dixie Classic Health Fair. Other participation included subscriptions to TODAY'S HEALTH and distribution of Health Cards.

SAFETY Almost all of the Auxiliaries cooperate with local Safety programs. Two Auxiliaries have become interested in the Gems program of Baby Sitter Safety Training. Several members attended the Statewide Women's Traffic Safety Seminar and Mrs. John C. Reece is on the Advisory Committee to the N. C. Traffic Safety Council, Inc..

SCRAPBOOKS Many Auxiliaries report having sent material in to the State Chairman and fifteen counties plan on sending their Scrapbooks to the State Convention.

SANATORIA BEDS Each Sanatoria Bed patient has received, gifts, cards, and small checks from its assigned county Auxiliary. A detailed report is elsewhere in this annual report.

STUDENT LOAN FUND Substantial contributions were made to the Student Loan Fund this year. There is a balance on hand as of 2/1/65 of \$3011.36 with fourteen loans having been made.

WA/SAMA Although our three medical schools all have organizations of student wives, only the group at the University of North Carolina is affiliated with the national organization. Efforts have been made

this year to interest the Duke wives and the Bowman Gray wives in joining the WA/SAMA, but have been fruitless. The Med-Dames at Duke were co-chairmen for our successful Fall Board meeting.

YEARBOOKS Auxiliaries were encouraged to have yearbooks and to plan their meetings in advance. Twenty-two counties reported having Yearbooks.

REPRESENTATIVES TO OTHER ORGANIZATIONS Each of the organizations listed in your GUIDE POSTS had a representative from the Auxiliary and close contact was maintained,

So you can see in this superficial report that, although every county did not participate in every project, the over-all picture is one of "Service to Others" throughout the State of North Carolina in an effort to have "Better Health for a Better World."

Mrs. Amos Johnson, President Auxiliary to the MSSNC

FIRST MEDICAL DISTRICT

The First District of the Medical Society of the State of North Carolina reflects upon its accomplishments and looks forward to a future of greater participation by its component county societies in the plans of tomorrow.

We have just completed a successful area-wide Sabin Vaccine program under the direction of your councilor with the assistance of professional aid.

Extension post-graduate courses have been completed under the sponsorship of The First District Medical Society and we look forward to another well balanced program of The Seaboard Medical Society at Nags Head this spring.

The First District Medical Society elected the following officers: President, Dr. J. M. Ruffin, Ahoskie, Vice-President, Dr. L. P. Williams, Jr., Edenton, and Sec.-Treas., Dr. Joe Lee Frank, Ahoskie, N. C. With their guidance we plan to make our Society programs more appealing and better attended.

T. P. Brinn, M. D., Councilor

SECOND MEDICAL DISTRICT

The 2nd Medical District of the North Carolina State Medical Society has had a good year. The annual district meeting was held at the beautiful Governor Tryon Hotel in New Bern, N. C. on September 25, 1964. Third District Congressman, Dave Henderson, was the dinner speaker, who whose the topic "Current Medical Legislation." A panel on G. I. Bleeding followed, with Dr. Steve Bartlett presiding, with Drs. Bell, Fearington, and Potter presenting aspects of the radiological, medical, and surgical approach. Thanks are due to Dr. Simmons Patterson, and the fine Craven-Pamlico group for their hospitality.

The Carteret County Society will be the hosts for the next meeting, and Dr. John Morris of Morehead was elected President of the 2nd District, with Dr. John Way as Secretary. Dr. Morris was unable to serve, and his successor is to be chosen from the Carteret County Medical Society.

As councilor, I have attended all state meetings, and have visited in the district. I would again urge all members to participate in local and state medical society affairs.

There is considerable interest in the 2nd District in promoting a two year medical school at East Carolina College. The progress of hospital construction, and the improvement in the caliber of medical practice in Eastern North Carolina has been almost phenomenal in the past few years. Professional conduct seems to be at the highest level ever.

Lynwood E. Williams, M. D., Councilor

THIRD MEDICAL DISTRICT

I hereby submit my Councilor Report for 1964. The Third District had a normal routine year for 1964. The Councilor was called to make only one minor investigation which was disposed of. Harmony and good will has prevailed.

We had two District Meetings during the year. One in the fall and another in the spring. As Councilor I have attended all Executive Council Meetings.

Dewey H. Bridger, M. D., Councilor

FOURTH MEDICAL DISTRICT

The Councilor has visited most of the counties in the Fourth District during the year. Professional and organizational activities remain active, and all relationships appear relatively harmonious. revitalized Fourth District Medical Society continues as the hub of District Medical Activities. Meetings are held semi-annually, with wives in attendance and Auxiliary activities held concurrently. Outstanding speakers have been obtained with remarkable regularity. The spring meeting is devoted to topics of socio-economic-political interest, and the fall meeting to scientific deliberations. Attendance and interest are quite good, and are undoubtedly enhanced by the continued publication of a periodic newsletter and by the efforts of the lay executive secretary, Mr. Jim Fulghmum and his staff at Communications Associates, Inc.

Edgar T. Beddingfield, Jr., M. D., Councilor

FIFTH MEDICAL DISTRICT

The Fifth District Medical Society, under the able guidance of it's President, Dr. W. H. Gentry of McCain, N. C., held it's annual meeting in October at the Mid Pines Hotel.

The meeting was well attended and a splendid scientific program presented dealing primarily with pulmonary diseases. At the business meeting held the same day, Dr. A. M Oelrich, the president-elect was installed as President of the society for the coming year, and Dr. Charles A. Speas Phillips of Pinehurst was elected the new president-elect. Dr. Phillips has served the Fifth District Society ably in the past few years as Secretary.

A discussion was held during the business session regarding the desirability of changing the present method of electing the District Councilor and member of the nominating committee of the State Society at a caucus of delegates during the annual meeting of the House of Delegates. As before expressed some members wished to allow the Fifth District Society to elect these officers at the District Meeting. Inasmuch as this change would entail a change in the State Society's Constitution and By-Laws, this matter was referred to the committee on Constitution and By-Laws for further action. The District Society plans to continue to sponsor an annual meeting and generally finds these meetings interesting and fruitful.

All eight component county societies in the District are functioning adequately.

H. H. Summerlin, M. D., Councilor

SIXTH MEDICAL DISTRICT

The membership of the Sixth Medical District of the Medical Society of the State of North Carolina has continued to participate actively in the meetings of the individual component societies. Interesting programs have been held and have included discussion and evaluation of national legislation as well as current medical society business of local interest.

The Councilor has assisted the state office of the medical society in routine investigations of the status of several physicians practicing in this area to the satisfactory of all concerned.

The Councilor and a good representation of the officers of the component societies attended the Conference of County Medical Society Officers and Committeemen at Pinehurst on February 6, 1965, and participated actively in the program and discussions at this meeting.

Representatives of the medical profession along with the Councilor attended an interesting and productive meeting of the North Carolina Congress on Medicine and Pharmacy held at Durham, North Carolina, on November 12, 1964. Many problems of mutual interest were discussed including common concerns in connection with the implementation of the Kerr-Mills bill in providing prescriptions.

The Councilor and an interested group of physicians also attended the Regional Meeting of the Association of Prosthetists and Orthotists at Durham, North Carolina, on March 6, 1965.

The Councilor participated in and enjoyed the Speech Training Seminar held by the North Carolina Medical Association in Durham on December 4th and 5th, 1965.

No problems involving malethics were brought to the attention of the Councilor. Generally the members of the Sixth District have continued an active year as physicians whether in practice, teaching, research or administration. Along with professional activities, these members have continued to maintain an active interest and participation in the affairs of the local and state medical societies.

John Glasson, M.D., Councilor

SEVENTH MEDICAL DISTRICT

Representatives of the ten county medical societies making up the Seventh District met for a special dinner meeting in Charlotte on Wednesday evening, September 16, 1964. Individual letters of invitation were sent out to total of 75 present and past officers of the various component county societies, and to past officers of the Seventh District Society which has given up its regular annual meeting.

Since we were honored to have Jim Reed, director of communications for the American Medical Association, as our guest and speaker for the evening, members of the Charlotte Public Relations Society were also invited. These men represent business, industry, and educational institutions in this area and are very much interested in the public relations problems of organized medicine. It provided an opportunity to bring together some non-medical people of influence with our own District representatives and have everybody hear a forthright and outstanding statement of the aims and objectives of the American Medical Association's Public Relations Program. A total of about fifty persons attended this very successful occasion and letters from six of the non-medical guests indicated that they had appreciated this opportunity to meet with us very much; comments from the physicians indicated that this was a mutually satisfactory get together and might well be repeated. Attendance was not restricted to officers of the component medical societies but each president was told to supply names of his officers and any others whom he would like to have invited and invitations were sent on that basis.

In addition to providing a pleasant meeting for the physicians of this district, it did provide an opportunity for us to learn about public relations problems in some non-medical areas during the discussion which followed Mr. Reed's talk.

David Goe Welton, M. D., Councilor

FIGHTH MEDICAL DISTRICT

This is my first report as a Councilor for the Eighth District.

The District Meeting originally scheduled for October in North Wilkesboro was cancelled after consultation with the Wilkes County Group. It was felt that lack of interest and poor attendance in the past justified this action, and your Councilor in his visits to five of the component societies has endeavored to obtain a concensus of the membership about future meetings. No decision has yet been made.

Two instances of unprofessional conduct on the part of members have been brought to the Councilor's attention. One apparently has resolved itself, and the other is still being considered.

Your councilor has endeavored to interpret the work and activities of the Society to its members and has been greatly encouraged by the courtesy and interest shown him during his visits and by the initiative and dedication displayed by the members in their respective county activities.

Louis Shaffner, M. D., Councilor

NINTH MEDICAL DISTRICT

As Councilor for the Ninth Medical District I am pleased to report no particular problems coming to attention during the year.

Our annual meeting was held in Lenoir on October 1st. The program arranged by Dr. Fred A. Thompson was excellent and was well attended. We are looking forward to our meeting this year in Salisbury under the leadership of Dr. Thomas Thurston who was elected President of the Ninth District for the coming year. Dr. L. H. Robertson was elected Vice-President and Dr. Paul Green was elected Secretary and Treasurer.

Thomas L. Murphy, M. D., Councilor

TENTH MEDICAL DISTRICT

There have been no unusual problems relating to the Practice of Medicine in the District this year. The Annual Meeting of the Tenth District Medical Society was not held last year. The McDowell County Medical Society has requested transfer to the Ninth District.

Your Councilor has attempted to keep in touch with the component County Societies during the year.

The Officers of the Tenth District Medical Society are:

President - Dr. George Macatee, asheville

Vice President - Dr. W. E. Mitchell, Bryson City, N. C.

Vice President - Dr. E. H. Stines, Canton, N. C. Vice President - Dr. Paul Hill, Murphy, N. C. Secretary - Dr. J. D. Coughlin, Asheville

Secretary-Elect - Dr. H. D. Severn, Asheville J. S. Raper, M. D., Councilor

ADMINISTRATIVE COMMISSION
(See Report of Committee on Finance)

ADVISORY AND STUDY COMMISSION

The annual report of The Advisory and Study Commission is favorable and optimistic. All nine committees have met and the individual reports of these committees will cover all pertinent details of deliberations, transactions and conclusions. There was at all times evidence of excellent cooperation. I. The Committee on Auxiliary Advisory and Archives of Medical Society History met at the September Conclave at Mid Pines and discussed various phases of auxiliary activities, and also plans regarding continuation of interesting and worthwhile medical history research. II. The Committee on American Medical Education and Research Foundation met at the Fall Conclave and discussed methods of increasing donations. An improvement was notes. III. The Committee on Blue Shield met and issued the Blue Shield Professional Services Index with unit values, and suggested new legislation for implementation of its usage. IV. The Committee on Constitution and By-Laws met in September 1964, and again in February 1965, to consider pertinent changes which will be

given in Dr. McMillan's report. V. The Committee to work with The Industrial Commission of North Carolina met in Raleigh on October 1, 1964, with the members of the Industrial Commission in Raleigh, and considered cases, legislative matters, and evaluation of various considerations of fees, practices, and certain problems. There was evidence of excellent rapport and cooperation. VI. The Committee on Medical Care of Dependents of Members of Armed Forces (Medicare) met at the Conclave in September 1964. A speaker from Washington, D. C., gave an excellent speech. Various matters regarding fees, schedules and practices were discussed. Favorable progress was reported. VII. The Committee on Advisory to Student A.M.A. Chapters met at the Mid Pines conclave, and student representatives from some medical schools were there. Plans were made to enlarge the scope of the work, plus plans for a larger social hour and dinner at the Annual Session of the State Society. VIII. The Committee on Relative Value Schedule met at Mid Pines in September 1964, and gave evidence of complete understanding of the intricate complexities of Relative Value Schedules. The California Schedule was reportedly issued in the late Fall of 1964 and will be studied and considered in the light of its potential usefulness in N. C., with appropriate necessary changes. IX. The Committee on Marriage Counselling met at the Mid Pines Conclave and projected plans for a symposium or meeting on this subject and subsequently made plans for a speaker at the Annual Session, along with a Dutch breakfast Conference on Marriage Counselling.

The individual reports of the various committees will contain more elaborate details on the important data under continuing consideration by these excellent committees. Their cooperation with their commissioner is gratefully received.

W. Howard Wilson, M.D., Chairman

ANNUAL CONVENTION COMMISSION

The Annual Convention Commission for 1964-1965 consisted of six Committees. As in previous years, the Committee on Audio-Visual Scientific Post-Graduate Instruction, headed by Dr. John C. Grier, Jr., arranged the audio-visual presentations for the Charlotte meeting. The Committee on Scientific Exhibits, headed by Dr. Fred H. Taylor, made arrangements for this phase of the program. The Committee on Scientific Works under the chairmanship of Dr. Leonard Palumbo did an outstanding job in arranging the programs for the General Sessions, to be held May 3-5, 1965 in Charlotte.

The Committee on Scientific Awards under the chairmanship of Dr. Lester Crowell, Jr., and the Committee on Credentials to the House of Delegates with Dr. Charles B. Wilkerson, Jr., has functioned and will continue to function as in previous years.

The final Committee under this Commission is a new Committee on Arrangements set up by President Raiford. The Secretary of the Medical Society, Dr.

Charles W. Styron, served as Chairman with Dr. Chalmers R. Carr as Co-Chairman. There were also two consultants appropriate for the Charlotte meeting plus ex officio consultants who serve as chairmen of the standing Committees stated above. Your Commissioner of the Annual Convention Commission feels that this is a considerable improvement in efforts to co-ordinate the planning of the Annual Convention and recommends that it be continued.

Paul F. Maness, M. D., Chairman

PROFESSIONAL SERVICE COMMISSION

All of the Committees of the Professional Service Commission met at the conclave of committee meetings on September 24, 25, 26, and 27 at the Mid Pines Club in Southern Pines, North Carolina. In addition, other meetings have been held for the Professional Insurance Committee and for the Physicians Committee on Nursing.

On September 25, 1964, in Southern Pines, the Disaster Medical Care Committee met and held an informative and active meeting. With the forboding potential importance of this committee, North Carolina physicians are urged to read with care the report of this committee.

The Eye Care and Eye Bank Committee met on September 25, 1964, in Southern Pines and a review of the business of the committee was held. The physicians attention was particularly called to questioning from the North Carolina Drivers License Division regarding eye examinations for determining fitness to drive a motor vehicle.

The Professional Insurance Committee was held many meetings throughout the year and also held a meeting at the Mid Pines Club on September 25, 1964. A program of the St. Paul Insurance Company "Top Brass" was presented. Mr. Lynch of the St. Paul Insurance Company reviewed the program of the company and pointed out the various aspects of the professional liability program. A report was given by Mr. Ralph Golden on the policies his Company sponsors.

The Necrology Committee met on September 26, 1964, at Southern Pines, North Carolina. Plans for the Memorial Service and the annual meeting in Charlotte were made.

The Committee of Physicians on Nursing has had many meetings during the past year. At the outset Ad Hoc Committee was appointed by the Chairman to review three articles on nursing of interest to physicians in general. These three were the report by Mr. Ray E. Brown entitled "Report of Survey of Nurse Education in North Carolina" published July, 1964, "The Proposed Revisions of the Nurse Practice Act," and also "Guidelines for Nurse Education in North Carolina as Expressed by the Board of Higher Education." This Ad Hoc Committee was appointed at a meeting of the committee of Physicians on Nursing held on August 5, 1964, in Raleigh, North Carolina. This Ad Hoc Committee met on September 1, 1964, September II, 1964, and October 25, 1964. From these meetings the opinions of the Medical Society and of the

Hospital Association were found to be similar on the three above mentioned reports and a critque of each was made. Another meeting of the committee of the Physicians on Nursing was held in Raleigh on November 12, 1964. The final meeting of the Ad Hoc Committee met with the Hospital Association Committee on January 22, 1965. From all of these meetings, it was the opinion of the physicians of nursing that support should be given to the diploma schools of nursing in order that better care for the partients in North Carolina could be maintained.

The Retirement Savings Plan Committee met at Southern Pines on September 24, 1964, at which time the current status of the Societys Retirement Savings Plan was reviewed. Comparisons were made with the AMA Retirement Plan and recent modifications of our plan were presented.

Mark McD. Lindsey, M. D., Chairman

PUBLIC RELATIONS COMMISSION

The Commissioner of the P.R. Commission submits the following resume of the Committees in this group; this summary includes certain highlights of the activities of each committee and the reader is referred to individual reports of each committee chairman for full details.

- 1. Hospital and Professional Relations. James S. Raper, M. D., Chairman. At the meeting of this committee on September 26, 1964, it was notes that the future of private practice of medicine may well depend upon the utilization factor of voluntary health insurance. It is mandatory, therefore, that physicians concern themselves with seeing that action on utilization committees is taken by each hospital staff to which they belong. The committee recommended that a statement to this effect be sent out to each member of the Medical Society of the State of North Carolina.
- 2. Committee on Legislation..Edgar T. Beddingfield, Jr., M. D., Chairman. This committee, which carries perhaps the heaviest load of any single committee under the very capable leadership of Doctor Beddingfield, has to consider, study, and recommend specific action on national legislation, state legislation, and related activities. The scope is so large that the reader is referred to Doctor Beddingfield's own report and also to the new "Legislative Newsletter" which this committee will put out periodically, serving a very useful purpose.
- 3. Medical-Legal Committee. Julius A. Howell, M. D., Chairman. This committee has started to organize teams of physicians and attorneys to present medical-legal problems for county medical society meetings; they have developed an approved a standard report form which has subsequently been approved by our Executive Council.
- 4. Committee on Public Relations. Philip Naumoff, M. D., Chairman. This committee also carries on very extensive activities and the reader is referred to the detailed report of its chairman. A highly successful Officers and Committee Chairmen's Conference was held under its direction in Pinehurst on February 6, 1965, and this was preceded on the even-

ing before by a dinner for new county society presidents and secretaries, a very worthwhile function which probably merits repetition. The chairman of this committee, along with officers of the state society, attended the A.M.A. Institute in Chicago in August 1964 and was kept busy throughout the year with the many and diverse problems which come into its category, all very competently handled.

The annual officers and committeemen's meeting is an excellent training and stimulating session for those physicians holding responsible positions in their county societies. At least one fourth of our county societies were not represented at the February, 1965, meeting. The meeting merits the time and attendance of every physician in the state. Plan now to attend next year's which will be the last Saturday of January or the first Saturday of February.

5. Committee on Rural Health. Edward L. Boyette, M. D., Chairman. This committee met on August 30, 1964, and considered a wide range of subjects from tetanus immunization and similar community immunization programs, a statewide program of farm and pond safety, proper labeling of agricultural poisons, to interest in any efforts which would improve highway safety.

6. Insurance Industry Liaison Committee. Frank W. Jones, M. D., Chairman. This committee continues to perform an extremely important function, meeting regularly every three months and sometimes oftener to review claims and disputes in a most thorough manner, and it is likely that a number of our membership are not aware of the scope and enormous amount of time contributed by the hard-working members of this committee. A very comprehensive, detailed report dated February 1965 has been prepared by the chairman and the reader is referred to it.

7. Committee Liaison to N. C. Pharmacy Association. John T. Dees, M. D., Chairman. This committee met September 24, 1964, and considered a very complete agenda. including such subjects as Kerr Mills implementation, refill permissions, physician ownerships of pharmacies, code of interprofessional understanding with the pharmacists, etc. The committee did arrange the first statewide congress on medicine and pharmacy in cooperation with the N. C. Pharmaceutical Association and this was held November 11-12, 1964, in Durham. It was very well attended by the pharmacists but could have been better attended by physicians, and it is recommended that this meeting be repeated annually and that more interest among physicians be stimulated.

8. Advisory Committee to the Department of Motor Vehicles. Simmons I. Patrick, M. D., Chairman. This committee has been very active and following its meeting last fall requested the executive council to change its name to "Advisory Committee to the Department of Motor Vehicles". This has been done. While the committee is working mostly now with the licensing department, later on they anticipate working with other departments. There is some lack of information about this program both among physicians and the public, and attempts will be made to rectify this. The five physician members of the committee plus thirty consulting physicians (anonymous) have the program working well and the committee does

meet periodically.

9. Committee on Association of Professions.. John R. Kernodle, M. C., Chairman. You have all received individual letters from Doctor Kernodle concerning this committee's attempt to increase interest among other professions to join with physicians, doctors of vetinary medicine, professional engineers, and pharmacists in this organization which provides a forum and opportunity for working together in our common objectives. A very successful dinner meeting was held on September 26, 1964, and the annual meeting is scheduled for March 24 in Raleigh; at this time members of the General Assembly will join the group for luncheon and Governor Moore will address the meeting.

David Goe Welton, M.D., Chairman

PUBLIC SERVICE COMMISSION

Your Public Service Commission is composed of:

- 1. Committee on Chronic Illness.
- 2. Committee on School Health.
- 3. Committee on State Board of Public Welfare.
- 4. Committee on Mental Health.
- 5. Committee on Maternal Welfare.
- 6. Committee on Cancer.
- 7. Committee on Occupational Health.
- 8. Committee on Veneral Disease.
- 9. Committee on Child Health and Poliomyelitis.
- 10. Committee on Physical Rehabilitation.
- 11. Committee on Anesthesia Study.

These committees are all active in their respective areas and have contributed tremendous service to the State in the name of the Medical Profession in North Carolina. Their meetings have been well attended. The chairmen have all given excellent leadership to their committees.

You are referred to the individual chairman's reports for the complete report of this Commission.

Thomas G. Thurston, M.D., Chairman

COMMITTEE ADVISORY TO THE AUXILIARY AND ARCHIVES OF MEDICAL SOCIETY HISTORY

Several years ago in an address to the Editors of the Associated Church Press, Ex-President Eisenhower said "If we do not understand that freedom and religion have an inescapable relationship, and that one is dependent on the other, particularly that all free values of Government are an attempt to transfer in the political field, what we believe in the religious field. We are then going to make no progress in combatting Communism." I want to add in any other field of endeavor.

I am especially interested in the close association and dependency our State Medical Society is upon the Auxiliary.

Emmet John Hughes in preparation of his book, "The Ordeal of Power," says "Leadership is not hitting people over the head. That's assault. Leadership is persuasion and conciliation and education and patience. It's long, slow, tough work." That's the kind of leadership the Medical Auxiliary is doing

day by day, year by year. The past year is no exception.

The fine work they have accomplished in Community Service, Disaster Prepardness, Health Careers, International Health, Activities of Legislation, Membership - 2287 as of February 20, 1965, the largest in history; particularly active in Mental Health activities. I emphasize the fund for Psychiatric research and treatment at North Carolina Memorial Hospital. This fund is increasing approximately \$1,000.00 per year.

Time and space forbids me going into detail on many important projects, such as, Rural Health, Radio, T. V. and Movies, Research, Safety, Sanatoria Beds, Programs, Student Loan Funds, and AMEF-ERF Fund.

We are sure the Auxiliary has fully met the challenge of the able President, Mrs. Amos Johnson, upon taking office last May.

Archives of Medical Society History

We are still at work in preparing this History. A great deal has been accomplished this year and only a few of the Subcommittees remain unfinished. These I hope to obtain within the next few months.

Roscoe D. McMillan, M.D., Chairman

COMMITTEE ON AMERF

This committee met on September 25, 1964, at Mid Pines Club, Southern Pines, N. C., to discuss accomplishments of 1963-64 and to plan action for 1964-65. One of the main problems was felt to be the indoctrination of county society officers in bringing the AMA-ERF program to their individual societies. It was suggested that this committee should arrange for a presentation by a member of the AMA staff at the annual winter meeting of officers in February 1965. An attempt to arrange this program was made, however, there were so many other topics already on the program that no time could be allotted to this committee's work.

It was also recommended that a meeting of the committee with representatives of the medical schools be arranged with a member of the AMA staff to be held prior to the February meeting. This was not accomplished, since the follow through program could not be arranged. (With earlier planning this might be accomplished next year.)

A special letter was placed in the Public Relations Bulletin calling all of the membership's attention to part of the AMA-ERF work and again encouraging the membership's participation with contributions. This was to supplement the appeal directly from the AMA.

The total giving in 1964 was \$9,597.00. This was an improvement over previous years, however, the participation by more members of the society could show that the physicians of North Carolina are really endorsing the AMA-ERF program.

Harry B. Underwood, M. D., Chairman

COMMITTEE ON ANESTHESIA STUDY

The Committee on Anesthesia Study met with its Commissioner at Southern Pines on September 24, 1964. In the past 3 1/2 years 655 questionnaires have been sent out, on the basis of death certificate reproductions made available by the Public Health Statistics Section of the State Board of Health. Three Hundred and forty-six of these questionnaires have been returned, in varying degrees of completeness, and form the basis of this report.

Ninty-three of these deaths were thought to be preventable from the standpoint of anesthesia and 6 additional cases were obtained during 1963 and 1964 from the Committee on Maternal Welfare. It is significant that, of the 93 deaths considered preventable by this Committee, only 25 were attributed to anesthesia and 10 others were marked questionable by the submitting physician.

In the majority of these 93 cases more than one factor related to the administration of anesthesia was involved. Following is a breakdown of the various factors encountered in this group:

	Factor Incide	Incidence		
a,	Anoxia associated with anesthesia	36		
b.	Overdosage of anesthetic drug	27		
С.	Error in choice of agent	22		
d.	Error in choice of technique	21		
е.	Mismanagement of anesthetic course	39		
f.	Error in preoperative care of patient	61		
g.	Error in operative care of patient	24		
h.	Error in postoperative care of patient	53		
i.	Hypothermia, undetected	2		
	Inadaguata resuggitation was a framework finding			

Inadequate resuscitation was a frequent finding and will form the basis of a separate report to the Section on Anesthesiology of the Medical Society of the State of North Carolina at Charlotte, N. C., in May, 1965. In many of these cases closed chest cardiac massage appeared to be a "mixed blessing" in that there was no effort to rule out ventricular fibrillation by electrocardiography when closed chest cardiac mas-

sage was not effective. Administration of multiple analeptics and vasopressors without mechanical support of the circulation was also frequently encountered. In no case of cardiac resuscitation was there a description of the use of Sodium Bicarbonate or Molar Lactate solutions.

For our purposes effectiveness of cardiac massage was described as the resumption of cardiac rhythm, even though temporarily, to maintain circulation. It is obvious that these are distorted figures in that an effective resuscitation who survives will never enter our files. In 12 uses closed chest cardiac massage was effective and in 15 cases it was ineffective but not followed by any other procedure. Closed chest cardiac massage was effective in 2 cases and ineffective in 2. Initial open chest cardiac massage was effective in 4. Defibrillation was employed in only 4 cases, one effective and 3 ineffective. Two reports indicated that their hospitals were not equipped with pacemakers or defibrillators.

There are many limitations to such a study as this. First, only deaths are considered. No "near misses," morbidity nor permanent impairment are called to our attention. Some of the deaths reach us by very devious routes. Associates, other Committees and even the fourth estate have pointed out preventable anesthetic deaths that did not appear in our file of death certificate reproductions. Liason was established in 1963 with the Committee on Maternal Welfare in order to obtain information on preventable anesthetic deaths in obstetrical patients. We have no figures on perinatal mortality as it relates to anesthesia.

Even though the coded and anonymous nature of this study is stressed there is a compliance rate of only 53 percent. Ninty-seven who chose not to return the questionnaires clearly implicated anesthesia as the causative factor on the death certificates. Following are a few examples from this group:

,	Cause	OI	Death	
Acute	cardi	ac	standstill	

Tracheal obstruction

Cardiac arrest

Cessation of Resp. and cardiac function

Cardiac arrest

Anoxic cerebral damage

Ventricular Fibrillation

Anoxic cerebral damage

Ventricular Fibrillation

Cardiac arrest

Cardiac arrest

Acute Respiratory Failure

Cerebral anoxia

Due To

Due To

Operative manipulation under anesthesia

Aspiration of vomitus

Small bowel obstruction

Ether anesthesia

T & A

General anesthesia for T & A

Respiratory obstruction I

Difficult General Anesthesia

Cardiac arrest during Anesthesia for Herniorphy

Anesthetic preparation for D & C

Cardiac arrest during Induction of Anesthesia

General Anesthesia for cholecystectomy

Anesthesia during Sinus Surgery

Ether Anesthesia for T & A

Under anesthesia during Appendectomy

Cardiac Arrest during General Anesthesia

Twenty-three of this series of preventable anesthetic deaths were autopsied, a rather low figure for death under these circumstances. There have been a number of cases, 4 very striking ones, in which autopsy findings absolved anesthesia.

The Committee expresses its gratitude to those physicians who have thoughtfully taken the time from their busy schedules to cooperate with the work of this committee.

Luther C. Hollingsworth, M.D., Chairman

COMMITTEE ON ARRANGEMENTS

The meeting of the Arrangements Committee was attended by the following members: T. S. Raiford, M. D., President; Paul F. Maness, Chairman, Annual Convention Commission; John S. Brabson, M. D.; Fred H. Taylor, M. D.; John C. Grier, Jr., M. D.; Leonard Palumbo, M. D.; James T. Barnes, Executive Director; Garland R. Pace, Headquarters Staff; Mrs. LaRue King, Headquarters Staff; Mrs. William Coe, guest; Mrs. Larry Berger, guest; Charles W. Styron, M. D., Chairman.

Mr. William Coe and Mr. Lar y Berger, representatives of the Cunard Steamship Company, presented information on a cruise projected for 1967. The problem of the cruise was discussed in great detail by the Committee and recommended that a cruise be rejected for the year 1967. Later the Council supported the recommendation of the Committee.

In the absence of Dr. Chalmers Carr of Charlotte, Chairman of arrangements for the 1965 meeting in Charlotte, a letter from him was read to the Committee. The Mecklenburg County Medical Society is to act as host for the reception on Monday evening, May 3, 1965.

It was agreed that the space at the Merchandise Mart was adequate for the annual meeting. The reception for the Exhibitors is to be staged at the Queen Charlotte Hotel and not at the Merchandise Mart.

The contract for the use of the Park Center for the President's Banquet and Ball had been executed at the time of this meeting. The Jan Garber Orchestra is to furnish music for the ball.

Press, radio and TV coverage had been previously arranged by Dr. Carr and members of his committee.

All Auxiliary functions will be staged at the Sheraton-Barringer and these arrangements had been completed by Mrs. Amos Johnson, President of the Auxiliary and her Committee in Charlotte.

The University of North Carolina will furnish all projection equipment and the required number of projectionists. The projectionists are familiar with the needs of the various Sections and General Sessions of this Society.

It was felt by the Committee that outside visitation, (general public) of the exhibit area would not be feasible.

Plans for the 1966 annual meeting are scheduled for Asheville and details of the meeting are being handled at the present time.

It was recommended that the 1967 meeting be held

in Asheville or Raleigh and that the 1968 meeting be held in Charlotte if the present meeting works out satisfactorily. It was felt that Durham and Winston-Salem facilities were not adequate to take care of the Annual Meeting.

The meeting adjourned at 10:00 P.M.

Charles W. Styron, M.D., Chairman

COMMITTEE ON SCIENTIFIC AUDIO-VISUAL POST-GRADUATE INSTRUCTION

A meeting of the Committee on Scientific Audio-Visual Postgraduate Instruction was held on Friday, September 25, 1964, at the Mid Pines Club, Southern Pines, N. C., for the purpose of developing the program for the Annual Meeting in Charlotte, N. C., May 1-5, 1965. It was decided to have the audio-visual program on Monday and Tuesday - morning and afternoon sessions. The Postgraduate and Audio-Visual Program is presented in the Program of the One Hundred Eleventh Annual Session of the Medical Society of the State of North Carolina.

John C. Grier, Jr., M.D., Chairman

COMMITTEE ON SCIENTIFIC WORKS

In a meeting of various officers and administrative staff held in the Society headquarters in Raleigh and attended by the Chairman of the Committee on Scientific Works, preliminary discussions concerning the Scientific Session were held. The names of various guest speakers were considered, and these were to be contacted by President Raiford. Various subjects to constitute the theme of the program were discussed.

The Committee on Scientific Works held its first and only official meeting on Thursday, September 24, 1964, at 9:00 a.m. in the Terrace Cottage of the Mid Pines Club. The following members were present:

Leonard Palumbo, M. D., Chairman

John F. Lynch, M. D.

Paul F. Maness, M. C., Chairman, Commission on Annual Convention

George E. Prince, M. D., Chairman, Section on Pediatrics

James B. Greenwood, Jr., M. D., Chairman, Section on General Practice of Medicine

R. Pinkney Rankin, Jr., M. D., Chairman, Section on Obstetrics and Gynecology

T. S. Raiford, M. D., President

James T. Barnes, Executive Director

Garland R. Pace) Headquarters

Mrs. LaRue King) Staff

It was decided that on the first day of the General Session the subject would be "The Diagnosis and Management of Urinary Tract Infections". Names of participants were submitted by the various members of the Committee. On the second day, Tuesday, May 4, it was decided to have a symposium on shock. On the final day of the program, Wednesday, May 5, it was thought appropriate to present a panel on Medical Education, the panel consisting of the former and present deans of the three medical schools in the

state. The details of this were to be worked out by the Chairman of the Committee.

On February 26, the Chairman of the Committee met with Mr. Barnes and Mrs. LaRue King. Final details for the General Sessions were worked out.

Leonard Palumbo, M.D., Chairman

COMMITTEE ON BLUE SHIELD

By appointment of recent Medical Society Presidents, the Blue Shield Committee is now composed of the following physicians:

Roy S. Bigham, Jr., Charlotte (1966) Robert P. Couch, Asheville (1967)

Willard C. Goley, Graham (1965)

Frederick C. Hubbard, North Wilkesboro (1967)

William A. Hoggard, Elizabeth City (1966) George W. Holmes, Winston-Salem (1966)

Max P. Rogers, High Point (1965)

C. Ronald Stephen, Durham (1965)

W. Z. Bradford, Chairman, Charlotte (1967)

In 1964 the Committee reported the adoption of the new High Option Blue Shield Program with allowances based on relative value units of National Association of Blue Shield's Professional Service Index, subject to modification at the discretion of the Committee to meet local conditions. The Professional Service Index was revised in December 1964, by the issuance of supplements based on recommendations of the Medical Advisory Committee of the National Blue Shield Association. The supplements were based on a new survey of Plan fee allowances in all states and established unit values for new procedures, which have become accepted since the original index was developed in 1961, and adjust some units for previously listed surgical procedures with a small increase in benefits of about two per cent being the net result. With the concurrence of the two North Carolina Plans that the changes could be accomplished within the framework of existing subscriber rates, the Committee voted to adopt the revised Professional Service Index schedule. The Plans are in the process of putting these changes into effect and printing new listings of revised allowances for surgical and professional anesthesia allowances. The new survey did not indicate present need for change in the medical, radiology or pathology sections of the Index. Neither Plan reports substantial sale of the new High Option Coverage during the first year, however, increased sales are anticipated as the Program becomes better established on the market.

The Committee has sought to clarify its functions and responsibilities. This was deemed necessary as the Committee has been confronted with numerous insurance problems that have arisen since the By-Laws of the Medical Society established a Blue Shield Committee, and since the "Statement of Understanding" between Society and Plans was formulated. Therefore, the matter was taken up with Dr. Roscoe McMillan, Chairman of the Committee on Constitution and By-Laws. It is our understanding that this Committee will recommend to the May 1965 House of Delegates that Chapter 10, Section 16, be amended so that the Blue Shield Committee will be authorized to provide

not only specific direction of the "Doctors Plan", but may also provide professional advice and counsel on matters relating to Blue Cross, indemnity coverages, Extended Benefits (which includes benefits for private duty nursing care, prescription drugs, etc.), and Major Medical coverage administered by Hospital Saving Association and Hospital Care Association, as requested. If approved, this will provide official sanction to participate in matters vitally affecting the increasingly complex field of prepaid health care.

At all meetings, the Committee has dealt with adjudications of unusual cases as requested by physicians or the Associations. Fee Schedule considerations have dealt with such matters as new vascular surgery, organ transplants, gastric freezing, photocoagulations, and many other diverse methods of treatment and procedures for which sanction was requested by establishment of a Blue Shield procedure code and benefit allowance. The Committee has felt that benefits provided for new techniques should usually be on an individual consideration basis until such procedures become established and generally accepted by the profession.

The Committee has especially appreciated the interest and attendance of President, Dr. T. S. Raiford, and President-Elect, Dr. George W. Paschal. The Officers of the Associations, Mr. E. B. Crawford and Mr. E. M. Herndon, have been fully cooperative and helpful at all times. The administrative aid of Mr. James T. Barnes, Executive Director of the Society and Mr. K. G. Beeston, Committee Secretary, is gratefully acknowledged.

W. Z. Bradford, M.D., Chairman

COMMITTEE ADVISORY TO N.C. BOARD OF PUBLIC WELFARE

The Committee Advisory to the North Carolina Board of Public Welfare throughout the year 1964 was closely in touch with the State Department particularly in reference to the implementation of the 1963 Legislation which provided that North Carolina implement the Federal Kerr-Mills Act as well as other areas of concern the the Department of Welfare related various medical aspects of their programs for public assistance and the oversight of general family welfare services and childservices where these involved medical considerations.

The committee held one formal meeting on September 24, 1964, at which a considerable representation was present and participated at this meeting. Dr. Bruce B. Blackmon served as acting chairman and at this meeting Dr. Cynthia Hardison, North Carolina Department of Welfare, Division of Medical Services, was present to discuss with the Committee the status of Kerr-Mills implementation in North Carolina.

The Medical Services Program of the North Carolina Department of Public Welfare includes the following services for those certified as eligible for services under the categories OAA, MAA, APTD, and AFDC; hospital inpatient service, hospital out-patient service, dental services, which are available only to those 65 years of age or older, and the prescription drug services program began January 1, 1965. Mr.

Russell R. Chambers is Director of Medical Services, of the Department of Public Welfare, Raleigh, North Carolina.

Hospital in-patient services require a physician's signed statement for authorization of each thirty-day extension.

Hospital out-patient services began July 31, 1964. Hospitals have the choice ofparticipating. Emergency room treatment is not covered by payment. North Carolina made no limitation on the number of outpatient services.

One physician has pointed out that some towns don't have out-patient services in their hospitals; however, it is commonly accepted nationally that such services may be rendered through usage of the Emergency Room as, or in place of out-patient departments. It was suggested if a recommendation was made to the Welfare Department that possibly fees could be paid for and x-ray particularly if the scheduling originates in the physician's office.

Another problem pointed out was that some of the physicians' offices are equipped to perform diagnostic services such as x-ray, etc., and many of these same offices are as much as twenty-five miles from the nearest hospital. The Committee felt these services in a doctor's office should be covered.

The question has also been asked why the regulations excluded emergency room coverage. This was due to Mr. Chamber's interpretation of the law. It was also pointed out that emergency room service is over used; however, there is emerging a new concept of the purposes and usage of Emergency Rooms in lieu of our-patient departments.

It should be stated that the Committee was aware throughout the early months of 1964 of the disposition of the leadership of the controlling board -- the N. C. Board of Public Welfare -- to disregard the provisions of implementing legislation of the Kerr-Mills Program, "Medical Assistance to the Aging" until it was more or less directed to do so by two opinions rendered by the Attorney General of the State of North Carolina. Up to mid spring 1964 at the same time there had been a disposition on the part of the staff of the Department of Public Welfare to concern itself with implementation and did indeed call upon members of this Committee and of the Medical Society frequently for advice and guidance not only of the Committee but of other knowledgeable officials of the State Medical Society. To this end your Chairman, the Past President of the Society, and President T.S. Raiford, M. D., as well as others did confer formerly with Mr. R. E. Brown and members of his staff in the Department of Public Welfare in the furtherance of guides and suggestions in reference to the implementation of the Medical Assistance to the Aging Program. Thus, it was that the hospital provisions of the 1963 Act as well as the Dental Services were put into effect in the summer of 1964. The outpatient service was negotiated and implemented some weeks later providing for medical investigative work relative to the MAA program. related as well to the other categories of Public Assistance. At least a rate was negotiated upon which out-patient services could be vendor compensated.

Various consultations were also carred out on the development of a prescription drug program and there

was a tentative plan during the early fall to implement this on October 1, 1964, but upon the arrival of this date the implementation of the prescription drug program was deferred by the Department on directions of the State Board of Welfare to June 1, 1965 and therefore the drug program began January 1, 1965. A recipient must request an authorization for prescription service from the local welfare department. Pharmacies elect to participate in the program.

A joint committee of the Medical Society and the Pharmaceutical Association suggested the following restrictions in the drug program which were adopted by the State Board of Public Welfare: (a) prescriptions limited to legend drugs only; (b) no prescription may be refilled; (c) the maximum amount payable for any single prescription is \$10.00; (d) no weight control drugs, vitamins or laxatives may be considered for payment. The dispensing physician can also sign an agreement with the welfare department.

The Committee at its September 24th meeting felt the drug service program should not be limited to out-patient service. The Committee also felt the recipient's authorization for prescription service should be for 60 days instead of 30 days.

The final outcome was the decision to limit the Drug Program to legend drugs as authorized by the State Welfare Department based on written prescription by licensed medical physicians with no authorizations of refills and a ceiling limit of \$10.00 per pre-Certain drugs, vitamins and common scription. preparations were excluded from the program. So in effect the 1963 Legislation authorizing Kerr-Mills is in operation at the writing of this report in effect to those authorized services that are uniformly available in the county jurisdictions of North Carolina, but, of course, with some appropriation limitations due to the fact that the most part, the other categories of public assistance -- such as OAA, APTD and AFDC -- had simultaneous services equivalent to those provided to MAA put into effect for these progreams too.

Other matters encompassed in this Committee's consideration during the year are as follows: A questionnaire on Medical Review Boards for Welfare applicants was sent out September 11, 1964, to all county medical societies requesting information as to whether they had a review board in operation at present. Out of 21 replies, ten societies said they did have them in operation.

By use of the review board, Wilkes County has cut the case load from 340 to 312. The number of new applicants to APTD has decreased about 35%.

Under consideration by the Committee is a proposed T.V. program by Channel 5 on the medical review team of welfare applicants and recipients based on medical reasons. The Committee felt such a program should be as widely disseminated as possible.

Most review boards are organized so physicians only have to serve one afternoon three times a year.

Senate Bill 310 passed by the General Assembly authorized boards of county commissioners with approval of county welfare boards to set up Medical Review Boards.

It was reported a brochure explaining the Board of Welfare's Medical Services Program will be made

available to the general public around the first of 1965. The committee felt a copy of this brochure should go to the physicians for information. It was also suggested that a separate brochure on the program should be developed for physicians. Dr. Hardison said the department had plans to send out information.

The Committee made to the Executive Council the

following recommendation:

To better acquaint physicians with Public Welfare's Medical Service Program, the Committee recommends county medical societies have a meeting with the county welfare director.

It was asked what the Medical Services Division of the Department of Public Welfare has requested from the A and B Budget for the next biennium. Mr. Barnes reported the Commissioner had this information in August but kept it confidential. Mr. Barnes suggested the legislative representatives in the counties may be of help in determining what this amount was.

The Committee expressed its appreciation to Dr. Hardison for her meeting to discuss this information. Dr. Hardison said she would relay the Committee's suggestions to the Department of Public Welfare.

Attached hereto and formally a part of this report are communications issued by the State Board of Welfare dated July 31, 1964, October 30, 1964 related to Medical Services Program; October 30, 1964 in regards to Prescription Services; October 14, 1964 directed to pharmacy cost and February 3, 1965 related to the Prescription Drug Program and printed pamphlet entitled "Medical Services Provided by Public Welfare in North Carolina" issued in January 1965 all of which have been distributed to every member physician in North Carolina as essential information in their individual efforts in caring for welfare patients and cooperating as a profession with the State Department of Public Welfare and with the county departments of public welfare.

Amos N. Johnson, M.D., Chairman

Statement of Medical Services Program of N. C. State Board of Public Welfare

R. Eugene Brown, Commissioner

The State Board of Public Welfare in its relationships with the North Carolina Medical Society realizes that many physicians may welcome information regarding the new Medical Services Program. The following outlines services available and procedures for obtaining services. More information can be obtained from your local County Department of Public Welfare and will be issued from time to time by the State Board of Public Welfare.

Four Categories of Public Assistance:

- Old Age Assistance (OAA) Money Payment
- Medical Assistance for the Aged(MAA) formerly OAA - No Money Payment category.
- 3. Aid to the Permanently and Totally Disabled (APTD) - Money Payment and No Money Payment.
 - 4. Aid to Families with Dependent Children (AFDC)

- Money Payment and No Money Payment.

(Money payment means a monthly cash payment for subsistence needs made to eligible persons. No money payment means that medical services only are provided.)

Medical Services Program for those certified as eligible for services under one of the categories listed above.

- 1. Hospital inpatient service
- 2. Hospital outpatient service (as defined by the State Board of Public Welfare).
- 3. Dental services (available only to those 65 years of age or older).
- 4. Prescription drug services (program to begin January 1, 1965).

No authorization for any service as provided by the State Board of Public Welfare's Medical Services Program can be made until the following has been accomplished:

- 1. The individual or a person authorized to act in his behalf must make application for assistance at the county department of public welfare in the county where the applicant is living.
- 2. The county department of public welfare, after taking the application, investigates the applicant's circumstances and, on the basis of its findings, makes a determination as to whether or not the individual is eligible under one of the four categories. These categories are: MASS, OAA, AFDC, and APTD,
- 3. If the applicant is found to be eligible under one of these categories, the county department of public welfare will issue authorizations for services as needed and as provided by the program.
- 4. If the individual elects not to apply for assistance or if he is not found to be eligible under one of the four categories, then no authorization for services can be made.

Division of Medical Services Out-Patient Clinic Visits (Definition)

The general objectives of out-patient clinic services has provided by the State plan are to provide diagnostic and therapeutic services to eligible recipients and not to provide emergency service or merely a quick convenient means of seeing a physician.

Methods for differentiating between out-patient visits and emergency room visits in those hospitals which do not have formally organized out-patient clinics and emergency rooms and use the same geographic area of the hospitals for both types of service are as follows:

- 1. Out-patient visits must occur during regular clinic hours (e.g. 8:00 a.m. to 5:00 p.m.) to be considered for payment. This excludes visits at night and during weekends and holidays.
- 2. Out-patient visits must include some diagnostic or therapeutic service other than physicians' services.
- 3. Initial out-patient visits scheduled by aphysician after seeing a patient may be considered for payment if the out-patient visit satisfies other criteria.
- 4. Initial out-patient visits for diagnosis or treatment of traumatic conditions are regarded as emergency visits and are therefore not in order for payment.
- 5. After the initial out-patient visit, only scheduled visits (that is, by appointment) can be considered for payment.

Implementation of Prescription Services for Public Assistance Recipients

Representatives designated by the North Carolina Medical Society and the North Carolina Pharmaceutical Association met with, consulted with, and advised, officials of the North Carolina State Board of Public Welfare in devising a plan of presceiption services for Medical Assistance for the Aged and public assistance recipients.

Enclosed copies of the Working Agreement between the North Carolina State Board of Public Welfare and the participating pharmacy and the cover letter to all pharmacies in this State demonstrate the plan as formulated. This material is sent to you so that you may be fully informed as to the details of this plan.

The practicing physician, who participates in helping these needy persons obtain these essential services, writes his presceiptions just as he does for

any other patient.

Beginning on January 1, 1965, the State Board of Public Welfare plans to provide presceiption services to public assistance recipients. These services will be administered by the 100 county departments of public welfare.

The State Board of Public Welfare serves four categories of assistance recipients. These are: Medical Assistance for the Aged (MAA); Old Age Assistance (OAA); Aid to Families with Deptendent Children (AFDC); and Aid to Permanently and Totally Disabled (APTD). Any person who is found to be eligible for assistance under any of these categories may, whenever he needs medicine, be authorized by the county department of public welfare to receive presceiption services.

The procedure whereby the cecipient obtains these services is as follows:

- 1. When a cecipient of one of the above assistance categories needs medicine, he goes to the county department of publis welfare and requests an authorization for Iresceiption service. If a person is not receiving assistance but needs medicine and is medically indigent, he should apply at the co7nty department of public welfare for a determination of whether or not he is eligible under one of the assistance categories.
- 2. The authorization for presceiption service is made by the county department of public welfare on the State Board of Public Welfare's form DPW-SS-14-P. The authorization is made to a specific pharmacy to render this service to the recipient; both pharmacy (ven. Tr) and recipient are named on the authorization. The recipient may choose any pharmacy to render this service provided the pharmacy owner/manager has signed an agreement with the State Board of Public Welfare to participate in this program.

This authorization may be taken by the recipient to the designated pharmacy or it may be mailed to the pharmacy by the county department of public welfare.

The pharmacy uses the bottom half of this authorization as an invoice on which to bill the State Board of Public Welfare for prescriptions filled for the designated recipient during any one month.

Prescriptions, within the program's limitations, written by any licensed physician or dentist may be filled.

At the end of each month, each recipient's prescription services are invoiced on the DPW-SS-14-P and sent to the Division of Medical Services, State Board of Public Welfare, P. O. Box 2599, Raleigh, N.C.

3. Each authorization - invoice (DPW-SS-14-P) is verified in all details and, if found correct, a check is written for each such claim. All checks for all vendors in any county are sent to the county director of public welfare and are distributed by that office to the proper vendors. In the check writing process, a vendor register is prepared for each pharmacy. This register details every claim and the check written for that claim. Copies of the vendor register go to the county director of public welfare, the vendor and the county auditor or other designated county fiscal officer.

The State Board of Public Welfare sincerely hopes that every pharmacy in this State will choose to participate in this program in order to serve the needs of the recipient citizens to best advantage and also to help utilize the county, state and federal funds available for these health needs to best advantage. Federal participating funds in this program range from 65% to 80% in accordance with the recipient's category; the non-federal portion is shared equally by county and state funds.

Enclosed are two copies of a "Working Agreement" form and a copy of the DPW-SS-14-P form. Please examine the "working Agreement" carefully before making a decision to participate in this program. Once a decision is made to participate, complete the agreement (name and address of pharmacy and signature of owner/manager or other person authorized to sign such agreement) and return the original to the Division of Medical Services, State Board of Public Welfare, P. O. Box 2599, Raleigh, N. C.

Please act promptly because a complete list of all participating pharmacies must be compiled and copies sent to all county directors of public welfare before January 1, 1965.

Also, please make a careful study of the DPW-SS-14-P form. This is the only form which the county department of public welfare may use to authorize prescription services and the county department is the only agency which may make these authorizations. Also, this is the only form which the pharmacy (vendor) may use to fill the State Board of Public Welfare for services rendered.

This is essential to efficient administration of this service and the adequate, accurate accounting for the use of public funds.

Because of limited funds, some control over the expense of the program is necessary. The following restrictions were recommended by the joint committee of the N.C. State Medical Society and the N.C. Pharmaceutical Association and adopted by State Board of Public Welfare with the cost aspect in mind;

(1) Prescriptions are limited to legend drugs only; (2) no prescription may be refilled; (3) the maximum amount payable for any single prescription is \$10.00; (4) no wright control drugs, vitamins or laxatives may be considered for payment.

Sample Working Agreement With Pharmacy

North Carolina State Board of Public Welfare

Working Agreement between the North Carolina State Board of Public Welfare and

Name of Pharmacy Address of Pharmacy City

County

in connection with pharmaceutical service to eligible public assistance recipients.

I agree to all of the following items:

- 1. Upon authorization by the County Department of Public Welfare, to fill prescriptions which bear the physician's or dentist's signature.
- 2. To supply legent drugs only as prescribed by the attending physician or dentist and dispense such prescriptions in the same quality container as customarily used for prescriptions for other persons.
- 3. Medical accessories are not reimburseable under the program. Typical examples of medical accessories are hypodermic syringes and needles, atomizers, nebulizers, hot water bottles and syringes, ice bags and caps, urinals, bed pans, cotton, gauze and bandages, wheel chairs, crutches, etc.
- 4. To price all such prescriptions in accordance with the regulations and procedures shown on reverse side.
- 5. Not to display any sign or device, or advertise, or in any manner state or imply that this pharmacy has been approved by the North Carolina State Board or Public Welfare.
- 6. To send to the North Carolina State Board of Public Welfare monthly an invoice of each prescription filled for a public assistance recipient, on the DPW-SS-14-P form in the manner described thereon.
- 7. On all prescriptions submitted for reimbursement under this Agreement, I will clearly record all required information including name of doctor, drug name and form dispensed, strength, manufacturer, quantity, price, date of service, and prescription number.
- 8. I reserve the privilege of cancelling this Agreement upon thirty (30) days notice to the Commissioner of Public Welfare and further, I reserve the right under this Agreement to decline to dispense any prescription which appears to be improperly executed or which in my professional judgement is unsafe as presented. I also understand that this Agreement may be cancelled by the State Board of Public Welfare upon thirty (30) days notice to me.

Date Name of Participating Pharmacy Signature of Pharmacy Owner/Manager Regulations and Procedures Governing Payment for Pharmaceutical Services for Eligible Public Assistance Recipients

- l. Prescriptions for eligible public assistance recipients shall be priced on the basis of wholesale cost, as listed in the Drug Topics Red Book and subsequent revisions and supplements, plus a professional fee of \$1.75. Wholesale cost is calculated on cost of size nearest the quantity dispensed.
- 2. In all charges, the odd cents shall be rounded off to the nearest multiple of 5¢.
- 3. A prescription, telephoned by the practitioner to a pharmacist, must be followed by the practitioner's written and signed prescription.
- 4. Prescriptions shall be filled within 15 days after being written by the physician. No prescription may be refilled.
- 5. Payment to the pharmacist can be made only after receipt by the State Board of Public Welfare of a monthly statement, listing each prescription by date, number, and price for which reimbursement is claimed on copies of authorizations for each recipient. (Original prescriptions must be kept on the pharmacy's file in accordance with North Carolina General Statutes.)
- 6. Monthly statements shall be mailed prior to the tenth day of the month following that in which the prescription is filled.

Since the implementation of the drug program a number of questions have been brought to our attention. The most frequent of these questions and the answeres to them are as follows:

Question: Does the \$10 limit on a single prescription include both the cost of the ingredients and the professional fee.

Answer: It does.

Question: Does the policy that "no prescription may be refilled" mean that the patient cannot receive repeated prescriptions for the same medication.

Answer: This limitation does not mean that the patient cannot receive repeated prescriptions for the same medication. The prescribing physician may prescribe a given medication as repeatedly as in his opinion is necessary. If the physician wishes to prescribe sufficient medication to meet a patient's need for a specific period of time such as one month, me may order all the medication on one prescription. However, this may exceed the \$10 limit per prescription. In such a situation he may order a sufficient number of prescriptions to meet the patient's needs during the period of time so that each prescription will remain within the \$10 limit; very close cooperation between the physician and the pharmacist is most helpful.

Question: Does the policy statement "a prescription telephoned by the practitioner to the pharmacist must be followed by the practitioner's written prescription" mean that the doctor after telephoning a prescription to the pharmacist must write out a

prescription and mail or deliver it to the pharmacist.

Answer: No. It does mean, however, that the pharmacist must immediately write the prescription as given to him over the telephone by the physician. The pharmacist after writing the prescription exactly as given to him by the physician, also adds the physi-

cian's name. The only time when this procedure cannot be followed is when narcotic drugs are prescribed. The original order for narcotic drugs must be personally signed by the prescribing physicians prior to delivery of the drugs.

(A Facimile of Form DPW-SS-14-P follows.)

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COMMITTEE ON CANCER

The Committee on Cancer held its annual meeting September 25, 1964, at Mid-Pines, North Carolina.

The Committee voted to submit a case history on cancer to the North Carolina Medical Journal. This had previously been discussed with the editor who indicated that he would edit and comment for the committee. These cancer reports will be written by members of the Committee on Cancer or other interested physicians.

The Committee on Cancer recommends increased funds for the Cancer Control Program, an additional \$100,000 for the current twelve months to go into the A Budget and another \$100,000 in the B Budget for expansion into the field of chemotherapy and to increase the hospital coverage which is presently going to 62 of the possible 160 hospitals in the state. At the present time the funds are exhausted in the first eight months of operation.

The Committee considered the request of several small hospitals who requested qualification under the State Board of Health Cancer Program. The regulation now in force requires that before a hospital can be approved it must offer surgery, radium, and x-ray treatments for cancer. This has been the position of the Cancer Committee and the Executive Council since the program was started.

The Committee discussed the advisability of including chemotherapy under the State Board of Health Cancer Program. However, it was throught this was not practical at this time since the funds are insufficient for a twelve months operation under our present regulations. If further money is appropriated by the State, chemotherapy could be added.

Dr. D. E. Ward, Jr., President of the Board of Trustees of the North Carolina Cancer Institute, Lumberton, North Carolina, reported that 219 patients were admitted and treated in 1964. The average daily census was 40. The Institute receives patients through the county welfare departments referred by physicians who have terminal cancer and are indigent. Terminal cancer patients treated in 1964 was the highest since its organization in 1952. Patients were admitted at the request of physicians from all sections of the state.

The chairman informed the Committee that the North Carolina Division of the American Cancer Society had organized a Laryngectomy Speech Clinic taught by Mr. Wilton Barnes each Friday afternoon at Memorial Hospital, Chapel Hill, North Carolina. This clinic is open to any laryngeciomy patient in the state for speech therapy.

The possibility of a cancer mobile for the detection of cancer in North Carolina was discussed. Due to the results from the recent GI cancer unit which was in operation in North Carolina the idea was not thought feasible at this time.

The possibility of programming cancer information to physicians through the educational T.V. network was considered. This idea will be studied for we feel there is great possibility in cancer education for physicians via T.V. programs.

D. E. Ward, Jr., M.D., Chairman

COMMITTEE ON CHILD HEALTH AND POLIOMYELITIS

The principal activity of the Committee this year has been advising and encouraging the county societies in implementation of mass oral poliomyelitis vaccine programs. All one hundred counties have now had successful programs. We are presently compiling the number of people receiving the vaccine, the precentage of the population, and the type of vaccine used. When these statistics have been received and calculated, we contemplate releasing them to the press with further recommendations to the citizenry regarding the importance of continuing use of the vaccine in infrants during their first year of life and current recommendations regarding booster doses of the vaccine.

Further activities of the Committee have been to serve in an advisory capacity to the Executive Council on matters that have presented themselves in the realm of child health.

Richard S. Kelly, Jr., M.D., Chairman

COMMITTEE ON CHRONIC ILLNESS INCLUDING TUBERCULOSIS AND HEART DISEASE

With the cooperation and constructive support of the State Medical Society, through its past and present officers, executive council, commissioner, and its active executive secretarial staff, the State Committee on Chronic Illness has continued to operate during the years of 1964 and 1965 toward the expressed goal previously outlined.

The present committee is composed of ten members, ten consultants, and one unlisted consultant. Its subdivision into seven sub-committees for special interest and working purposes has continued as outlined in our previous report. The members of the committee and the consultant group have been selected because of their special interest in the field of chronic illness in all groups and also on the basis of the area of their practice, so that the committee can be represented in all political and geographical districts throughout North Carolina.

The emphasis of committee activity continues to be placed on stimulation of interest in Home Care Programs, especially in those health units in which Home Care Programs are established. At the same time it attempts to concern professional and lay elements in unorganized health districts for the need to establish Home Care Programs. In the course of this year, additional plans have been activated, bringing a present total to forty one health units operating actively.

The second area of special interest by this committee is that of Nursing Home Accreditation. A considerable number of nursing home operators in the State of North Carolina have been contacted and attempts made to interest them in the program operated by the National Council for the Accreditation of Nursing Homes. This is a joint undertaking by the American Medical Association and the American Nursing Home Association.

Personal contacts with Nursing Home operators

have been made by several members of this committee. All operators of licensed Nursing Homes in the State of North Carolina have received various brochures and application forms. Through a joint project with the North Carolina Nursing Home Association and the State Society's Committee Illness, a special joint letter was issued. This accompanied the second mailing of application forms. As a result there is a reported small group of applications now pending.

Letters, pamphlets, brochures, information summaries and booklets on Home Care Projects and Accreditation Programs are being mailed or presented steadily to physicans of this State. These originate from National, State or local sources; issued by professional and non-professional interested groups.

Despite the mass of material sent throughout the State, it is surprising to find that members of the County Medical Societies have little understanding of the need, scope, advantages, or soundness of the programs. All too frequently there is a suspicion that this is another trend toward the controlled practice of medicine. In those County Societies or health areas in which personal contacts can be made and the program clarified, increased activity is noted and the programs may be considered quite successful.

It is the feeling of this committee that as inevitable changes occur in the practice of medicine, Home Care Programs offer a continuing personal relationship between the patient and physican. Also, the support and constant control of these local programs remain under the continuing direction of the local physican, engaged in the private practice of medicine.

Full committee meetings were held in September of 1964 and February of 1965. At both of these meetings, interested professional and para-medical representatives were asked to meet and report to the committee. In addition the Committee has maintained its attendance and participation in meetings pertaining to Chronic Illness and Aging on the National State and local area levels. These excannges and participations are essential to continued communication, planned coordination and the demonstration of continued professional interest.

The committee has maintained liason with the Advisory Council of the State Board of Health, in relation to general health matters and to Home Care Programs. In relation to the latter there have been scattered area meetings with County Society Officers and Chairmen of Chronic Illness Committees. The "shop talk" film strip on Home Care Programs has enjoyed wide distribution among diverse health units within the State.

The committee has been involved directly and indirectly with the implementation of Kerr-Mills legislation throughout the State. On several occasions its members have met with County Medical Societies, meeting jointly with representatives of hospital administration, welfare departments and nursing homes.

Representation of this committee at mental health programs continues. Of special interest is excessive bed occupancy in the mental institutions of the

State of North Carolina by the chronically Ill and aging group.

The State Joint Council for the Health Care of the Chronically III and Aged met in July 1964 and February 1965. It has demonstrated a continuing interest in the care of long term illness.

It is recommended that close liason with the Council be maintained and that the medical profession continue its active support and direction. Aseries of meetings relating to the care of the chronically ill and aging, sponsored wholly or in part by the American Medical Association, have been timely, interesting and informative.

At the full meeting of the Committee of Chronic Illness in September 1964 the committee recommended to the Executive Council that it approve forms for the evaluation of inmates of rest homes and homes for the aging. It also approved the recommendation of the Rural Health Committee regarding tuberculin skin testing of school children.

In February 1965 at the full meeting of the committee, recommendations were made to the Executive Council (1) regarding the compliance with the regulation concerning the health status of residents of rest homes and (2) that it recommend to the General Assembly of the State of North Carolina that it authorize payment of sufficient funds to nursing homes to cover the reimbursable costs of the care of welfare recipients.

The majority of the projects of the Committee on Chronic Illness are, and should be long range in nature. This is particularly applicable to the firm establishment of the Home Care Programs in North Carolina. With continued active interest and perserverance, the goal can be reached, but the need for a program of stimulation will remain. In this connection methods must be devised to stimulate physican interest and the exchange of information at local levels. Since other private and governmental agencies are finding it difficult to communicate at local levels, it is possible that a suggested fact-finding research program be jointly undertaken. This is now is an exploratory phase.

We plan to maintain committee relationship with professional groups and agencies, interested in the improvement of standards and services for the chronically ill and aging, through communication, coordination and demonstrated cooperation.

Emphasis on rehabilitation with particular reference to the Stroke Program is a continuing project of this committee. It will attempt to carry the experience and training of the teaching hospitals into area hospitals, local community hospitals and to other agencies involved in this needed care.

The work of the Committee on Chronic Illness is extensive, detailed and time consuming. However, it is also rewarding to those who contribute to its function. We believe that operating within the framework of the Medical Society of the State of North Carolina, it will continue to explore, test, evaluate and transmit ideas leading in long term patient care.

Thomas R. Nichols, M.D., Chairman

COMMITTEE ON CONSTITUTION & BY-LAWS

(Makes report to the First Meeting of the Annual Meeting of the HOUSE OF DELEGATES, Sunday, May 2, 1965.)

COMMITTEE ON CREDENTIALS OF DELEGATES

The North Carolina Medical Society met in Greensboro, North Carolina on May 3-4-5-6, 1964, for their annual meeting. The Credentials Committee was present and working at the opening of the session of the House of Delegates at 2 P.M. on May 3rd. All delegates were checked and certified to the Secretary of the Society. Dr. Robert M. Whitley, Jr. of Rocky Mount, was present for the original and succeeding meetings, along with the Chairman.

No particular problems arose during the meetings, except one or two questions of certification, which were cleared through the Executive Scretary.

Charles B. Wilkerson, Jr., M.D., Chairman

COMMITTEE ON DISASTER MEDICAL CARE

The Committee met as a part of the Annual Conclave at Southern Pines on September 25,1964. It was perhaps the most comprehensive meeting of this Committee, in that never before have so many professional groups, and State Agencies met to discuss the problem in which they share a mutual interest. In addition to the Commissioner, Dr. Mark M. Lindsey, a majority of the Committee was present. Representatives from the following Agencies and professional groups were present.

- 1. General Edward F. Griffin, and members of the staff from the North Carolina State Office of Civil Defense.
- 2. Mr. Samuel Hawkins, North Carolina Department of Health, and representatives of the D.H.E.W.
- 3. Mrs. Marie B. Noell, North Carolina State Nurses Association.
- 4. Mr. John C. Ketner, North Carolina Hospital Association.
- 5. Dr. Harry Spillman, North Carolina Dental Society.
- 6. Mr. W. J. Smith, North Carolina Pharmaceutical Association.
- 7. Mr. C. L. Ketner, North Carolina Veterinary Association.
- 8. United States Army and Air Force Liaison Officers as representatives of Fort Bragg and the 3rd Army Command.
- 9. Mrs. John Robertson, Chairman, Auxiliary of the Medical Society.
- 10. Mrs. Amos Johnson, President, Auxiliary of the Medical Society.

MEND coordinators from each of the Medical Schools in North Carolina were present. Following a discussion of the MEND program by Dr. William A. Anylan, Dean, Duke University School of Medicine, each of the coordinators told of their programs at their respective schools. Of unusual interest was the report of Dr.

Warner Wells, Coordinator of the MEND Program at The University of North Carolina School of Medicine, in giving a summary of research done in Durham-Orange County, regarding the anticipated problems of shelter care.

Communication and rapport was again established through the interest and cooperation of Lt. General j. w. bowen, Commander of Fort Bragg, and XVIII Corp Area, in sending 4 liaison Officers to this meeting. They assured us of their interest and willingness to help in times of Disaster within the limits of their commitments.

The North Carolina Pharmaceutical Association, through its representative, Mr. W. J. Smith, submitted a prepared statement outlining the Responsibility and Additional Functions of the N. C. Pharmaceutical Profession in the State Disaster Health Services Program. He was pleased to have the opportunity to participate and the Committee was glad for the privilege of hearing him.

Mrs. Marie B. Noell, Executive Director of the N. C. Nurses Association reported that most Schools of Nursing have introduced courses of instruction on Disaster Nursing -- some have not, but are being urged.

Dr. Harry Spillman, N. C. Dental Society reported that his organization is trying to get each County Society to give courses of training in Advanced First Aid. They are eager to work with the Medical Society.

Mr. John H. Ketner, N. C. Hospital Association reported on an Ambulance Service Survey, and offered cooperation.

The N. C. Veterinary Association indicated through Mr. C. L. Ketner, that it has been confining their Civil Defense Program to inspection of, and the saving of meats and food. They want to coordinate their efforts and program with that of ours.

Mr. Samuel Hawkins, representing the N. C. Department of Public Health, discussed the (1) 200-Bed CDEH, and pointed out that we now have 50 prepositioned hospitals, all of which have been inspected and updated for a 30-day capability. (2) He reported of the Progress of the Medical Self-Health Program in the State. Up to now 6677 have been trained. Some schools have accepted it as a part of their curriculum, but it still remains a perogotive of the local School Board.

The outstanding contribution of the meeting was the report of General Edward L. Griffin, on a Summary of Achievements of the N. C. Civil Defense Agency from 1961-1964 inclusive.

The Auxiliary to the Medical Society Committee on Disaster Medical Care was represented by its Chairman, Mrs. John Robertson. She offered their services and cooperation. Also present was the President of the Auxiliary, Mrs. Amos Johnson.

This meeting made the Committee aware of the fact that interest in this problem is spotty; that most progress has been made by an energetic and enthusiastic few and that there is much to be done to bring our State's physicians and people into a state of preparedness.

The Chairman of this committee met with that of the North Carolina Dental Society on February 10th

to assist and offer advice, regarding developing and implementing their program.

George W. Paschal, Jr., M.D., Chairman

COMMITTEE ON SCIENTIFIC EXHIBITS

The Committee on Scientific Exhibits for 1965 had its first meeting at the Mid-Pines Club, Southern Pines, North Carolina, September 25, 1964. Those present were Drs. Frederick H. Taylor, Chairman; James F. Newsome; Robert E. Miller; Max P. Rogers. Also in attendance were Mr. James T. Barnes, Mr. Garland R. Pace, and Mrs. LaRue King of the head-quarters staff.

At this meeting our committee discussed techniques for obtaining good exhibits, and assignments were made to each committee member to glean the various upcoming national meetings for good scientific exhibit material.

Following this, the committee members worked at the various national meetings, and obtained a large number of applications for exhibit space. Over 75 applications were received for scientific exhibit space.

The Committee on Scientific Exhibits met again in the chairman's office on February 1, 1965, for selection of the exhibits to be shown. Those in attendance were Dr. Frederick H. Taylor, Chairman; Dr. Jack Hobson; Dr. Robert Payne; Dr. Robert E. Miller; Dr. John Glenn; Mr. James Barnes. Forty-six exhibits were finally selected with great difficulty. A number of excellent exhibits had to be rejected simply because of a space limitation. Exhibits were selected from all over the country, and the committee attempted to diversify the program as much as possible.

The final action of the committee will be in working with the Shepard Display Company to set up the actual exhibits at the time of the meeting at the Merchandise Mart in Charlotte, North Carolina.

Fredrick H. Taylor, M.D., Chairman

COMMITTEE ON EYE CARE AND EYE BANK

Over nine hundred eyes, for eye tissue transplantation, have been handled by forty ophthalmologists during the last fourteen years through the state wide NORTH CAROLINA EYE-BANK, Inc. with head-quarters in their own building at 2041 Queen Street, Winston-Salem, N. C. 27103.

Educational programs about BB guns and other firearms have been sponsored, in additiona to eye donor programs. One hundred and eighty-eight physicians rendering eye care in North Carolina have received three separate mailings, questionnaires, etc., from the Committee.

The Committee reaffirms that: (1) the relationship of the eye physicians and the Medical Society of the State of North Carolina be strengthened; (2) the N.C.E.E.N.Y. Society coordinate with the scientific session of the Medical Society of the State of North Carolina; (3) ALL legislative suggestions regarding eye care, from the eye section and from the N.C.E.E.N.T. Society, go through the Medical Society of the State of North Carolina to the A.M.A.; (4)

the Medical Society of the State of North Carolina Relative Value Fee book, pages 26 and 27, be corrected as follows:

5435	Refraction without cycloplegia	3.0
5436	Refraction with cycloplegia	3.5
5448	Removal of foreign body under	
	slit lamp	3.0
5415	Complege fitting of prosthesis	8.0
5460	Fitting of contact lens	25.0

which has been referred to the Committee on Relatime Value Schedule; (5) the Form DL-78 #2, N. C. Department of Motor Vehicles, Drivers License medical report, be amended to read:

- "I. Do you see two? Yes No
 - 2. Are you receiving blind aid? Yes No
- 3. Do you receive double deduction for loss of vision? Yes No

VISUAL: Visual acuity:

- 1. Without glasses: RE 20/ LE 20/ BE 20/
- 2. With glasses: RE 20/ LE 20/ BE 20/" a copy of which was mailed to the Liaison to N. C. Highway Patrol on Traffic Safety.

L. B. Holt, M.D., Chairman

COMMITTEE ON FINANCE

This report will be given orally to the House of Delegates.

Wayne J. Benton, M.D., Chairman

COMMITTEE ON HOSPITAL AND PROFESSIONAL RELATIONS

This Committee met in Southern Pines at the Fall Conclave of the Medical Society. No specific problems relative to individual physicians have been referred to the committee. We have had considerable discussion of the problem of hospital utilization. Recommendations have been made to the executive council and action taken.

The Chairman of the Committee took partina panel discussion of "The Hospital and You" at the conference for county officers in Pinehurst.

J. S. Raper, M.D., Chairman

COMMITTEE TO WORK WITH THE NORTH CAROLINA INDUSTRIAL COMMISSION

This Committee has been utilized to a greater extent in evaluating unusual fee problems than at any time during recent years. The Committee met during the year periodically with the Commissioners and Medical Director, but had very few real problems. The Committee has taken under consideration recent bills presented in the Legislature which would involve surgeons doing traumatic surgery in the state. Certain inequities involving non-medical practitioners of the healing art have presented problems which have not altogether been solved.

The Committee continues to be a close means of

liaison between the physicians of the state and the Industrial Commission as well as the employers and insurance carriers. The continued careful appraisal and able assistance of Dr. John Morris as Medical Director of the Industrial Commission has made this Committee's work serve a real purpose for medicine in this state.

Ralph W. Coonrad, M.D., Chairman

COMMITTEE ON INSURANCE

The full Committee met on September 25, 1964, in Southern Pines with representatives of the Administrative Office of the Medical Society, representatives of the St. Paul Company, and the full membership of the Committee. The Professional Liability Insurance Program was reviewed since its inception in 1956; this has showed, since this time, progressive increase in participation among the members of the Medical Society. It was pointed out at this meeting that because of the reclassification a slight total premium increase had occurred, but that the total premium increase was not significant. It was felt that the program was actuarially sound at the present time, and was one of the strongest professional liability programs in the country. Representative of the St. Paul Company pointed out that his company was not obligated to insure a member of the Medical Society of the State of North Carolina just because he is a member of the society. The primary purpose of this program is to provide members the strongest possible coverage, and protection at the lowest cost. In view of the gradually increasing participation and the apparent strength of the program, it is entirely possible that a rate reduction can be achieved during the coming year.

At the conclusion of the discussion of the Professional Liability Program, Mr. Ralph Golden discussed business overhead and major hospital policies his company writes at the endorsement of the society. It was pointed out that both of these programs are superior to other policies available, but that increased participation is necessary to strengthen both of these programs.

Joseph W. Hooper, Jr., M.D., Chairman

COMMITTEE ON LEGISLATION

Nineteen Sixty Four and the early mouths of 1965 have been busy times for the Committee on Legislation. At the time of the writing of this report, intense interest in health affairs at both the State and National levels is very evident with the North Carolina General Assembly and the 89th Congress both in session, and these have produced many challenges for the profession.

The tradition developed several years ago of the Society maintaining closer liaison with the North Carolina Congressional Delegation was continued in February, 1965 when approximately 20 physicians representing all areas of the state journeyed to Washington for two days of legislative briefing at the United States Chamber of Commerce Public Affairs Conference, visits to individual congressmen in their offices, and attendance at various other functions in the

nations capitol. Both the congressman and the physicians seemed to feel that this was a worthwhile session and your Committee believes that future such sessions should be carried out at appropriate times, and especially we do recommend that a significant representation from the Society attend each of the annual Public Affairs Conferences of the United States Chamber of Commerce.

We were all pleased that the 88th Congress did not act on the "Medicare" King-Anderson Bill. However, we all realize at the time that this was but a temporary respite, and at the writing of this report, we are now faced in the 89th Congress with a "Medicare" Bill which for the first time has been favorably acted upon by the House of Representatives, as a component part of a large omnibus health care measure. This bill now goes to the Senate and every effort will be made during the hearings before the Senate to defeat this bill.

Although it is uncertain at this time as to the ultimate fate of definitive congressional action on "Medicare" it must be acknowledged that most observers believe that this will be enacted into law. It is the feeling of your Committee that against federalized medicine, we have lost a very significant battle but we have not yet lost the war. We know very well that the proponants of "Medicare" regard this as but a stepping stone to total socialize medicine. While we do not look with favor upon "Medicare", it is the feeling of the Committee that should the measure be enacted into law as now appears likely, that it should be our policy to continue to provide the very finest professional care available to all persons in all economics circumstances, and to continue to develope the philosophy of the Kerr-Mills approach, in which go vernmental aid is restricted to those in some degree of economic need. It is our belief that by pursueing this course, we can contain "Medicare" and prevent its expansion into a system of total socialized medicine.

Continuing liaison has been maintained with our representative from Congress both by frequent personal messages, telephone calls, correspondence, and telegrams from the Committee and other offices of the Society directly to the Congressman, and also by a revival of the "Operation Hometown" which was so effective two years ago. A recent innovation in our national legislative campaign was the development of a "Task Force" in each County Medical Society providing for rapid communication between local leaders in medicine and their congressional representatives. Continuing utilization is also been made of the congressional keyman approach in each of the various districts.

In the campaign regarding national legislation, the House of Delegates of the American Medical Association voted to allow each State Medical Society to develope its own campaign and to provide matching funds from the AMA with which to finance the various state campaign. With the endorsement of the Executive Council, your Committee has participated in this cooperative program with the American Medical Association. Various mailings of correspondence, pamphlets, informational materials, etc., have gone out from time to time to the entire membership as

well as to those physicians involved in the local legislative committees. Note should also be taken of the fact that with the permission of the Hospitals Savings Association, Mr. Kenneth Beeston, an employee of that association has again been made available on a part-time basis to the Committee on Legislation for active help during the current national legislative campaign. His remuneration is a part of the cooperative program with the AMA. We are grateful to Mr. Beeston and to his employer for the significant help that he has provided to us again.

In the area of national legislation, the activity of the Committee has not been restricted to the "Medicare" issue, but communication has been directed to the Congress on various other issues profecting medical care. These are too numerous to be recounted in detail here. In an effort to improve radid communications from the Committee on Legislation to the individual members of the Society, within the past few months the Committee has inaugurated a new newslatter type publication "Legislative News," which is mailed out to the entire membership from time to time bringing up-to-date information on current legislative issues. Two issues of this publication have been mailed at this time and subsequent issues are planned.

In the area of State Legislation, the 1965 General Assembly appears to have gotten off to a rather slow start and at the time of the writing of this report no State Legislation of momentous impact regarding health care has as yet been enacted or seriously considered by the Assembly. The Committee has appeared before the Appropriations Committee of the Legislature to endorse a certain budgetary request of the North Carolina State Board of Health. Many consultations with Legislators have also been held regarding other bills. Our help was enlisted in the writing of the legislation now before the Assembly which is commonly called the "Good Samaritian Act." Consultations have also been held with Legislators regarding certain bills under consideration involving the licensing and/or certification of psychologists in North Carolina. Our advice has also been sought both by proponents and opponents of a proposed twoyear medical school at East Carolina College, and although the Society has taken no official stand on this proposal research data and assistance has been provided to both groups. We have also endorsed the appropriations request of the State Department of Public Welfare for the continued operation of the Kerr-Mills Program. The Committee has also met regularly with the Committee on Liaison to the North Carolina State Department of Welfare and has attempted to be of assistance in bringing the Kerr-Mills plan into smooth and effective operation in North Carolina.

A bill has been introduced which would amend various sections of the general statutes covering voluntary health insurance plans, commercial health insurance plans, and also eye care services provided by any governmental agency to the effect that Optometrists would be placed on a completely equal footing with Opthalmologists in providing eye care. The Committee has alerted the Society's Committee on Eye Care as to this possibility and it is planned that

prior to the Annual Session this issue will have been resolved in legislative committee hearings before the Assembly.

The Legislative Committee has been represented at each of a long series of meetings held with the Committee on Nursing meeting at time with the representatives of the North Carolina Hospital Association and with representatives of the State Board of Nursing. These meetings were held to consider a possible revision of the Nurse Practice Act. Certain objections posed by the Medical Society to items offered for encorporation into the new act were acknowledged and all of our objections have been met and these items have been deleted from the bill as it is to be introduced into the Assembly. It is the conviction of the Committee on Nursing and the Committee on Legislation that it is essential that adequate support be proveded for the existing three year diploma schools of nursing if this state is to have a continuing adequate of registered nurses to meet the health care needs of the state. Because of the serious financial difficulties in which most diploma schools now find themselves, and because several of these diploma schools have ceased operations in the past few years, and because these schools have for many years funished 92% of the registered bedside nurses practicing, financed by the local non-profit hospitals and the patients served therein, all of which has been done at no expense to the state, it is therefore recommended that the General Assembly consider making a direct state subsidy to the local hospital operating such three year diploma schools of nursing. This recommendation was discussed at length with representatives from the North Carolina Hospital Association and it was agreed that the Hospital Association would sponsor legislation seeking such finds for these schools. However, the Hospital Association Executive Committee has reconsidered and have informed us that other items deserve priority in their legislative goals in this session of the General Assembly and that they do not intend to pursue this request. The Committee on Nursing has met again and has directed the Committee on Legislation to prepare and have introduced into the General Assembly a request for appropriations sponsored by the Medical Society to provide direct state subsidy to these diploma schools of nursing in the amount of two hundred and fifty dollars (\$250.) per student nurse a year. It is anticipated that once this bill is introduced that considerable help will come in support of this bill from various legislators, from the hospitals operating diploma schools of nursing, and probably also from the North Carolina Hospital Association itself.

Many other items of somewhat lesser importance have also been brought to the attention of the Committee concerning state legislation but most of these have been handled effectively through the help of our Executive Director and through the help of our Attorney, Mr. John Anderson. Daily legislative activity is closely monatored by our Executive Secretary, Mr. James T. Barnes, and our legal counselor Mr. John Anderson, and by the Committee Chairman and approximately 100 bills have so far received special attention for their bearing on health affairs and medical practice. Advice and guidance has been frequently

sought from other Society Committees and members and in so far as possible the tradition policies of the Society have prevailed in our expressions of attitude.

Committee wishes to acknowledge the effort of all who have made the hundreds of speeches before medical and lay groups, the dozen television appearances, the thousands of miles traveled, the writing of many thousands of letters, and the energies expended in support of our legislative goals.

The Chairman feels that we are especially indebted to Jim Barnes, John Anderson, Bill Hilliard, Dick Nelson, Ken Beeston, Kay Zeigler, and to all of the headquarters staff efforts in the area of this committees responsibility, which often times have been far beyond the call of duty.

Edgar T. Beddingfield, Jr., M.D., Chairman

NATIONAL LEGISLATION COMMITTEE (Division of Legislative Committee)

There has, of course, been considerable activity in legislation on the National level during the past year. However, there is nothing specific or unusual which will not be reported by Dr. Beddingfield, Chairman of the Committee on Legislation.

Donald B. Koonce, M.D., Chairman

DOCUMENTARY PRESENTATION COMMITTEE (Division of Legislative Committee)

There has been no occasion during this year for this Committee to function.

Hubert McN. Poteat, Jr., M.D., Chairman

COMMITTEE ON MATERNAL HEALTH

The important work of the Committee on Maternal Health has proceeded smoothly for the Chairman throughout 1964 with the able assistance of the new Committee Secretary, Mrs. Helen Russell who has been a very apt student at the proceedings of the The analysis of Maternal deaths has Committee. claimed much of the committees time and this process enjoys very excellent cooperation of most of the Practitioners in North Carolina. The Committee has undertaken to project its influence into the area of leadership in the practice of medicine where a general interest may effect the welfare of the women of North Carolina, namely in the area of family planning clinics, therapeutic abortion, and human reproduction education in public schools.

A total of 106 Maternal deaths have been recorded during 1964 (Table No. 1). Of these 35 were white, 69 nonwhite, and 2 Indians. Toxemia is again the leading cause of maternal deaths with 19. The remaining deaths were in this order of occurrance: Embolism 13, Hemorrhage II, Cardiac 9, Infection 7, Anesthesia 3, and Other Obstetrical 13. There were 30 deaths due to Non-obstetrical cause and one unclassified. The total number of maternal deaths due to primary obstetrical problems show a rather significant reduction over recent years, representing 76 as opposed to 92

for 1963. The Toxemia deaths remain approximately the same with 22 occurring in 1963 and 19 in 1964. There was significant reduction in deaths due to hemorrhage from 17 in 1963 to 11 in 1964. This is an encouraging decrease since hemorrhage deaths are so frequently associated with problems in management and judgment.

The statistics on birth rate furnished by the Public Health Statistical Service are not available for 1964. However, for 1963 the total live births were 107,322 which shows a continuation in the decline in birth rate since 1950, representing approximately 2000 less than 1962. The number of white live births of 73,499 is the lowest rate since 1952 and the number of non-white live births of 33,873 also represents a decrease, and the lowest number since 1948. Of the total live births in 1964, 100,248 were hospital deliveries. There were a total of 7,074 non-hospital deliveries. In the home 2,499 were attended by physicians and 4,575 by midwives (Table No. 11).

The three thousandth Maternal death was recorded during the month of September 1964. It is our ambition to have these cases coded through the IBM machine and prepared for report during the coming year.

The full Committee met at Mid Pines on September 25, 1964, in an important session. A brief review of "The Therapeutic Abortion Study Project" which was started early in 1964 was given. The response of the questionnaire has been varied, indicating that the objectives of the project were not clearly understood by all who received the letter. Those who have reported are apparently the hospitals where no therapeutic abortions have been done in the past several years, and/or those where there is an apparent abuse of the procedure of therapeutic abortion by some of the staff. It is clear that the abuse of therapeutic abortion on a phychiatric basis is a problem in some instances involving a single physician in a hospital. Two hospitals reported therapeutic abortions for hyperemesis gravidarum on a repeated basis. The most valuable accomplishment of the project at this date is that conscientious staff members have used this project letter as a basis for organizing a therapeutic abortion committee in their hospitals. During this meeting there was extensive discussion of the new law on voluntary sterilization, Article 19, Chapter 90 of the Generl Statute of the State of North Carolina entitled "Sterilization Operations." The following resolution was adopted by the Committee, "Whereas, the General Statute of North Carolina, Chapter 90, Article 19, paragraphs 271, 272, 273, 274, and 275 make it clear that Physicians and Surgeons are authorized to perform certain operation upon the reproductive organs of certain persons when requested to do so, the Committee on Maternal Health therefore recommends to the Executive Council of the Medical Society of the State of North Carolina urge that the hospital by-laws concerning voluntary sterilization operations be ammended to include the following; 1. To prescribe the consent which shall be required to be given for the performance of operations. 2. The time in which the same may be performed. The conditions prescribed in the statute with which compliance is required. 3. It is further pointed out that this statute establishes the legality of the sterilization operation but does not in

any way alter the medical indications for such procedure as tubal ligation or vasligation. Therefore no necessity for altering existing regulations in the hospital concerning medical indications for such procedures.

A third item of business was discussed concerning "Population Explosion in North Carolina?". It was pointed out in this discussion that although there is a decline in the total live births in North Carolina there is strong evidence that there is a continued high birth rate among the socially and economically deprived segment of our population. Based on this evidence plus a continued high rate of illegitimacy, particularly among the low economic groups and the nonwhite, it is highly advisable that family planning programs including contraceptive clinics be established for this group of people throughout the State. Cognizance was given to the Charlotte-Mecklenburg County Health Department Planned Parenthood Clinic which has been in operation for four years noting the considerable economic savings to the Welfare Department through an active Health Department A report was then made on the recently established Planned Parenthood Clinic which has been established in Winston-Salem through the Forsyth County Health Department and the auspices of the Department of Obstetrics and Gynecology of the Bowman Gray School of Medicine. The Public Service Commissioner, Dr. Thurston asked that the Chairman of the Maternal Health Committee report back to the Executive Council of the Medical Society offering a discussion on this type of program in addition to an alternative program which may be adopted to the smaller counties where the clinic might be on a smaller scale but equally as effective. The Committee on Maternal Health stands ready to offer any assistance in helping a county health department establish such a clinic and the services of the Personal Hygeine Section of the State Health Department are also available in demonstrating special techniques to any Practitioner in North Carolina upon the request.

The Chairman of the Maternal Health Committee presented a paper in Miami Beach, Florida to the South Atlantic Association of Obstetricians and Gynecologists on the subject, "Problems in Obstetrical Anesthesia" in February of 1964. This paper was discussed by Committee Member, Jesse Caldwell. This article was published in the American Journal of Obstetrics and Gynecology, Vol. 90:1, 81-87 - September 1964. A rather interesting article on "Some Maternal Health Problems of a Rural Community" was published by the Chairman in the North Carolina Medical Journal, Vol. 25; pp. 341-351 - August 1964.

The Chairman wishes to extend the services of the Maternal Health Committee to any physician or physician group in North Carolina who would care to have any special problems discussed by any member or group of members of the Committee.

TABLE II

Maternal deaths for 1964 - Total 106

Toxemia		
Embolism		

19

13

Hemorrhage	11
Cardiac	9
Infection	7
Anesthesia	3
Other Ob.	13
Non-Ob.	30
Unclassified	1
	106
White	35
Non White	69
Indian	2
	106

TABLE II Total live births for 1963 - White - Non White - Total

In hospital deliveries	73,122 - 27,126	- 100,248
Home deliveries - M. D.	246 - 2,253	- 2,499
Home deliveries - Midwi	fe 81 - 4,494	- 4,575
		107,322

W. Joseph May, M.D., Chairman

MEDICAL-LEGAL COMMITTEE

1. Review of work done to date:

The Medico-Legal Committee met in Raleigh on March 13, 1964 and the following items were considered.

- (1) Delegation of therapeutic procedures to paramedical personnel. It was felt that although there was no litigation pending in regard to this type of thing in North Carolina, the problem was a real one.
- (2) Establishment of a clinic for executives. It was the considered opinion of the committee that such a plan was contrary to the North Carolina Law.
- (3) Standardized medical report forms. It was proposed to work out a satisfactory and suitable standardized medical report for physicians to use, this to be done jointly by the Medico-Legal Committees of the N. C. Bar Association and the N. C. Medical Society.
- (4) The formation of physician-attorney "teams" to present medico-legal programs. The committee felt that this was a worthwhile plan and approved the proposal. Details were to be worked out in conjunction with the Medico-Legal Committee of the N. C. Bar Association.

A joint meeting of the Medico-Legal Committee of the N. C. Medical Society and the N. C. Bar Association was held on June 4th in Raleigh. The purpose of this meeting was to work out details of the plans to standardize medical report forms and to arrange for "teams" to participate in the joint meetings of the local bar associations and medical societies.

A meeting of the Medico-Legal Committee was held in Pinehurst on Friday, September 25, 1964, and the two projects of standardized medical forms and medico-legal "teams" were further discussed. Conferences have been held between the chairman of the Medico-Legal Committee of the Medical Society and the Medico-Legal Committee of the N. C. Bar Association in regard to the final plan for sponsoring such medico-legal "teams."

Joint meetings were held in some twenty-three counties during the past year.

11. Unethical actions:

No incidence of alleged unethical conduct on the part of physicians have been reported to the commit-

111. Recommendations for the future:

Final completion of the plan for active participation on the part of "teams" of physicians and lawyers to stage medico-legal programs at the county level. Compilation of a booklet of laws pertaining to physicians and the practice of medicine.

Julius A. Howell, M.D., Chairman

COMMITTEE ON MEDICARE Medical Care Armed Forces Dependents

The Military Dependents' Medical Care Program operated on a stable basis throughout the year 1964, as evidenced by the comparison of the number of physicians' claims and the amounts paid during the years 1963 and 1964 respectively. The benefit provisions of the Program continued without significant change. There has been some talk of making retired military personnel and their wives eligible for civilian care under the Program; however, at this writing, I know of no actual pending legislation. The lapse of twenty years since the end of World War II has increased the retired ranks and makes for some problem at military hospitals. The issue may turn on the outcome of pending federal legislation for medical care of the aged.

The Annual Report for 1964 from our Fiscal Administrator, Hospital Saving Association, is attached, with comparative statistics for the past two years. This Report indicates that over the past eight years a total of \$15,900,826.00 has been paid to North Carolina physicians and hospitals under the Military Dependents' Program - a significant factor in support of community hospitals and free choice of private physicians.

The former Executive Director of the Program, Major General H. W. Doan, retired from the Army on September 1, 1964. The Committee expresses appreciation for the excellent cooperation given by General Doan in the administration of the Program. Our relationship with the Office for Dependents' Medical Care continues to be very satisfactory under the direction of Brigadier General Norman E. Peatfield, successor to General Doan and a person with whom we have previous pleasant association during his prior tour of duty with the Office for Dependents' Medical Care.

The Committee has called meetings as needed and consulted with individual Committee members by telephone and letter. Special report cases of unusual and complex nature were adjudicated by the Committee at these meetings and by mail throughout the year.

Hospital Saving Association has continued to give excellent administration and cooperation. The counsel and aid of Mr. James T. Barnes and his staff at the headquarters office of the Medical Society have been invaluable.

The Committee recommends to the House of Delegates that the Society continue to contract with the

Government in the operation of the Military Dependents' Medical Care Program with specific direction to the Executive Counsel to continue, revise, or discontinue the Program as they see fit according to future developments.

D. M. Cogdell, M.D., Chairman

Annual Report - 1964

To the Medicare Committee of the Medical Society of the State of North Carolina From

> Hospital Saving Association Chapel Hill, North Carolina

Hospital Saving Association has completed its eighth year as Fiscal Agent for the Medical Society of the State of North Carolina under a Contract to reimburse physicians for care provided the wives and children of active duty servicemen. From 1957 through 1964, \$8,380,155 has been paid to North Carolina physicians for 101,987 care reports. Comparative statistics for the year 1963 and 1964 are as follows:

Number of Claims Paid 12,603 12,677 Amount Paid \$1,022,564.34 \$1,042,554.58

During 1964, Hospital Saving Association personnel held a series of meetings, with doctors' secretaries and hospital insurance personnel, at which the Military Dependents' Medical Care Program was explained and discussed, as well as the various Blue Cross and Blue Shield Programs. These workshops were considered beneficial to physicians' office staffs in understanding the Program and the preparation of reporting forms and will be continued.

Under separate Contract, the Association reimburses hospitals for care provided military dependents who are eligible to receive benefits. From 1957 through 1964, 75,423 claims were paid to North Carolina hospitals in the amount of \$7,529,671.

We wish to express our sincere appreciation and gratitude to the Committee on Military Dependents' Medical Care, its Chairman - Dr. D. M. Cogdell, and to Mr. James T. Barnes, Executive Director of the Medical Society of the State of North Carolina, for the cooperation and guidance in the administration of the Military Dependents' Medical Care Program.

Date: Feb. 4, 1965

K. G. Beeston, Director Professional and Government Relations

E. B. Crawford Executive Vice President

COMMITTEE ON MENTAL HEALTH AND MEDICINE AND RELIGION

The Conference for County Medical Society Mental Health Chairman was held on March 14 and 15, 1964, to which an outstanding faculty of mental health leaders across the country was invited. This meeting was attended by over 100 official delegates from medical societies across the state representing three-fourths of the physicians in the state. At this meeting we were impressed with the interest of the non-psychiatrist physician in the mental health program and

their determination for placing into action what they had learned at the me-ting. Psychiatrists were also represented in good number at the meeting. These instructions were given to county medical society mental health chairmen who attended:

A) See to it that the other members of your mental health committee are appointed.

B) Call an initial meeting of your committee as directed in the Guidelines.

C) Provide leadership for the Mental Health Planning Council in your county.

A "Report of Proceedings of Conference for County Medical Society Mental Health Committee Chairmen" was prepared and distributed to other members of this committee and its subcommittees, as well as other interested persons in and out of the state.

On June 8, 1964, the chairman and subcommittee chairmen met with representatives from the Mental Health Planning Staff to answer questions about the mental health activities of the Medical Society, including its overall organization, membership, purpose, goals, ongoing activities, etc. In cooperation with the Planning Staff, a detailed questionnaire was distributed to a selected sample of physicians in the state to provide the Medical Society and the Planning Staff with a better understanding of the participation, functions and attitudes of the members of the Medical Society related to mental health at all levels in the The official analysis of the returns from these questionnaires has not returned as yet, but will be helpful in program development by the Mental Health Committee.

Informal admissions to state hospitals have been urged. On 9-18-64 a letter signed by both Dr. Raiford and the Chairman of this committee was sent to county medical society mental health chairmen urging them to promote informal admissions to state hospitals. In fifteen counties of the state, we were told that medical certification (a less formal type of admission procedure) has still not been utilized as an admission procedure so far this year. On April 13, 1965, a meeting is to be held in the Medical Society's office with representatives from the N. C. Bar Association, the N. C. Mental Health Association, the N. C. Department of Mental Health, and the Medical Society to prepare a proposed brochure on "Mental Health and the Law in N. C." to present in an easily understandable form the new laws in N. C. with emphasis toward informal admissions to mental hospitals.

Some thirty representatives from N. C. attended the Second AMA Congress on Mental Health held in Chicago on November 5 through 7, 1964. We were flattered at this meeting that our Executive Director was invited to speak on some of the mental health activities in N. C. Mr. Barnes' report was most well received and by formal action of our committee, it was requested that a copy of his remarks be reprinted in the N. C. Medical Journal.

Miss Kay Ziegler, Dr. Nicholas Stratas and the Chairman attended the Eleventh Annual AMA Congress for State Society Mental Health Chairmen on March 5 and 6 in Chicago. We were pleased that Miss Kay Ziegler, representing the State Medical Society's office, was invited to this conference to talk on "Effecting Mental Health Programming for County

Committees."

Dr. Phil Nelson, member of this committee, served as our representative to a Conference on Planning Comprehensive Mental Health Services in Washington, D. C., sponsored by the American Psychiatric Association. Rev. Fred Reid, consultant to the subcommittee on Medicine and Religion, served as our representative to the Regional Meeting of the AMA's Committee on Medicine and Religion in Atlanta on March 8 and 9.

On March 11 and 12, the Annual Meeting of the Committee on Mental Health was held in joint simultaneous sessions with the Annual Meeting of the N. C. Mental Health Association. This meeting was the first time in our nation that an annual meeting of a state medical society mental health committee and a state mental health association have held joint simultaneous sessions. Over 500 participants attended this meeting with approximately 100 physicians in attendance. An outstanding faculty of nationally prominent speakers participated in this meeting as was arranged by Dr. Charles Llewellyn, Program Chairman. Through his leadership, this meeting was sponsored with the cooperation of the American Medical Association and seven pharmaceutical houses. The need for a cooperative effort between physicians and the lay was emphasized throughout this meeting in the establishment of effective community mental health programs.

This year has seen the activation of the Medical Advisory Council to the Board of the N. C. Department of Mental Health under the chairmanship of Dr. George Hamm and Dr. John Kernodle, as co-chairman. It is desired that a very close relationship be developed between the Advisory Council and the Committee on Mental Health and Medicine and Religion to keep the physicians in the state actively involved in the program of the N. C. Department of Mental Health. One of the main mental health problems under consideration is the increasing number of elderly patients in the mental hospitals.

The subcommittee structure of this committee has been continued this year with Dr. Charles Vernon, Chairman of Physician Education; Dr. A. Hazel Zealy, Jr., Chairmen of Public Education; Dr. Lloyd J. Thompson, Chairman of Children's Services; Dr. Tom P. Jones, Chairman of Alcoholism; and Dr. Dan A. Martin, Chairman of Medicine and Religion. Individual reports from these chairmen have been requested for inclusion in this report to the President.

Subcommittee activities of particular note include:

- A) A very successful training session for psychiatrists and general practitioners was held 2-19 through 2-21 in Raleigh in cooperation with the Academy of General Practice, N. C. Department of Mental Health, and the N. C. Neuropsychiatric Association and the N. C. Mental Health Association, Dr. D. A. McLaurin served as project director for this program which was financed by a grant from the N. C. Department of Mental Health.
- B) A joint report from the Children's Services Subcommittee and the Children's Service Committee of the N. C. Mental Health Association was prepared describing the mental health services in the state at the present time and recommending proposed changes

for the future. This report is to be prepared in brochure form and made available for distribution in the near future. It has been suggested that this report serve as a sounding board for a multidisciplinary type of conference involving the various agencies in N. C. concerned with mental health of children to be held sometime within the next year to determine what course should be taken in the implementation of the recommendations of this report.

C) The Medicine and Religion Subcommittee has undertaken a program to promote medicine and religion programs in county medical societies. Some of these programs by county medical societies have been held so far and have been very well received.

The success to date which the Mental Health and Medicine and Religion Program of the Medical Society has enjoyed has been largely due to the efforts of the Subcommittee Chairmen, Dr. Charles Llewellyn, Dr. Ted Raiford, Dr. George Paschal, Dr. Edgar Beddingfield, Dr. D. A. McLaurin and the untiring efforts and cooperation of the State Medical Society Office directed by Mr. James Barnes, Miss Kay Ziegler and Mr. William Hilliard.

John L. McCain, M.D., Chairman

SUBCOMMITTEE ON ALCOHOLISM COMMITTEE ON MENTAL HEALTH AND MEDICINE AND RELIGION

No formal meetings of the Sub-Committee on Alcoholism have been held during the year 1964-5. Many informal meetings of two or three have taken place, correspondence and direct communication has been fairly extensive, and there have been the brief exchanges before and/or after the regular meetings of the parent committee, on mental health and medicine and religion.

Work on programs concerning Alcoholism continues at increasing pace and effectiveness throughout the state. There have been increases in local community Flynn Christian Fellowship information centers. Homes have added units, serving primarily the homeless alcoholic. Alcoholic anonymous groups are increasing in the State Prison Farm units, and this particular approach is showing increasing effectiveness as the decrease in both percentage and numbers of returnees to Prison System facilities, where the signal factor of imprisonment was alcoholic beverage excess. Use of the "Breathalizer" for detection of degree of intoxication in suspected drivers is increasing in use throughout the State. Clinics and follow-up Clinics are increasing, although the work in these facilities with alcoholics is not The number of "Spiritual Retreats" for long-term treatment of voluntary admissions for alcoholism is slowly increasing, and the degree of effectiveness is this tangent of approach to treatment is manifest by the concrete fact that a waiting list is in effect at each facility. The Wilmith Hospital (for Alcoholics0 in Charlotte, is moving to new buildings with an increase in available beds.

All State Hospital Units now have a specified number of beds available for alcoholic patient admissions, with encouragement of voluntary admission procedure, although legal committment and admission through the Courts is still in practice. A waiting list is found to be long at every facility. The Alcoholic Rehabilitation Center at Butner still is operating at capacity, and steps are in progress to make similar Centers available in large city centers, as this approach to therapy has proven highly successful and very much in demand.

Increasing awareness of the "Illness" nature of Alcoholism is more apparent now than ever before, and the effectiveness of all approaches to treatment, all resources of help, are being approached by an ever-increasing number of alcoholics, and/or family members, for help. The stigma is still there, however, and is still being keenly felt in these ways: Hospitals still refuse to accept alcoholic patients under that primary diagnosis; Insurance coverage is still poorly met for alcoholic patients, primarily because physicians are ambivalent in their terminology in filling insurance forms, just as they continue to be ambivalent in provisional diagnosis for purpose of securing hospital beds.

This last statement reveals the fact that still most physicians will not accept a patient who presenting need is treatment of withdrawal symptoms of the acute drinking bout. Physician-participation in local community projects concerning alcoholism is sadly limited in most areas.

Interesting, informative and provocative exchange of correspondence between members of the Committee have taken place this past year. Papers presented in various areas have been well-received, panel-discussion participation by several on many occasions and to diverse audiences have found a degree of community response that has been gratifying. Several papers have been published in those media where large audience participation will be found. TV appearances, radio talks, lectures before Medical Students and Nurses have been many. Co-operative meetings with members of ministerial associations on community level have found a most heartening response.

The big problems, however, of facilities located in widespread areas of the state; the need for representative voice on the State Hospitals System; better and a more dependable continuity of care for all alcoholic patients, and particularly for the physician-alcoholic is still a desperate need; consistency of diagnostic definition is of basic importance if we are now or ever to have insurance recognition of the need these patients have for suitable coverage. All these, and more, constitute emphatic immediate and continuing needs.

It was disheartening to find that the few physicians who were appointed to local County Medical Society Sub-Committees on Alcoholism, withdred from such committee service. However, recommendations are being prepared for presentation to the County Medical Society presidents, and the committee chairmen of the County Committees on Mental Health and Medicine and Religion, in hopes that the suggested names will be accepted by the component society presidents and committee chairmen. Considerable work is being put into the quient search for physicians who honestly and earnestly accept alcoholic patients

as bona fide patients, and treat them with the same understanding objectivity and sympathy traditionally given all those in need of medical care, are being identified in each County Medical Society area, and will be approached for possible willingness to serve on these sub-committees, if their names are favorably considered by each Society.

Work on a realistic nomenclature proceeds slowly, most of all because of the awareness of the unwillingness of most physicians honestly to indicate the implication of alcoholic beverage in the obviously correct admission diagnosis, and insurance diagnosis of such cases. It is to be hoped that this release from ambivalence and end to the self-struggle we all have with stigma diagnosis will strengthen the public image of the integrity we all enjoy within the profession.

Respectifully submitted, Thomas T. Jones, M.D., Chairman

SUBCOMMITTEE ON CHILDREN'S SERVICES

The 1964 report of this subcommittee gave an outline of the various areas for service and for prevention, - starting with pre-marital considerations and continuing through certain periods of life into adolescence.

At a meeting of the subcommittee, September 21, 1964, the report was reviewed and the following points as recommendations for action by the overall mental health committee were formulated:

I. Premarital:

The original aim of the subcommittee was to increase the premarital counseling and marriage counseling in general on the part of doctors, ministers and others.

Discussion led into the question of laws related to the premarital examination, laws concerned with epilepsy, consanquinity, and other items in the light of present day knowledge of genetics and even biochemistry.

Should the law require a complete physical examination, including a vaginal examination and even pelvic measurements as found in the laws of some other states? It was notes that a rather extensive examination is now required in order to get a driver's license.

It was agreed that laws alone are not the answer to these needed services. Physicians should recognize and carry out their responsibility in these fields with a minimum of specific laws.

All of the above items are the concern of other committees and of groups outside the medical society. Individual studies have been made, but it is recommended that the Institute of Government or some other body pull together all aspects of laws pertaining to the premarital situation and prescribe the necessary remedies.

2. Mental Retardation:

Although Mental Retardation has been split off from mental health in many ways and at all levels, this subcommittee has continued to include it as a part of the general mental health services for children. Recommendations pertaining to the early diagnosis and treatment are to be found in the body of the report.

The specific topic of PKU was discussed in detail with the question of the need for laws and directives in this field. The incidence of this disorder is now estimated at 1 in 10,000. An early diagnosis within a few days after birth is crucial. The Guthrie test, nwo required in hospitals in Mass. and N. Y., may give false positives and is not fully accepted at the national level. This and similar tests are to be watched from the standpoint of becoming required

The Phenistick test, valid some days after birth, is generally accepted, but with the disadvantage that the mother must be trusted to use the test and report her findings. This method has been accepted by our State Board of Health and Supplies of Phenisticks have been sent to local health departments for use in well-baby clinics. Many local private practitioners have not been reached in this way.

Attention is called to the fact that lawsuits against physicians are pending for negligence in not applying this test. It is recommended that the medical society, through appropriate channels carry on in the developments in this field and that testing be made universal in practice in N. C.

Also, it is recommended that an exhibit on PKU be arranged for the 1965 annual meeting of the Medical Society.

3. Schools:

Without any intended poaching on the field of public education, this subcommittee recommends that the medical society urgently back Dr. Charles F. Carroll, State Superintendent of Public Instruction, in the establishment of kindergartens as a part of the public school system.

This is definitely in the interest of mental health. The goal of kindergartens should not be the teaching of the rudiments of the "three R's", but rather for the culture of the social-emotional development of the child. Also, for the impoverished or the overprotected child, - the child deprived of sensory and emotional stimulation, the experience of "learning to learn" should be provided before he or she enters the first grade at the age of six or sometimes almost seven.

Also, for the State Department of Public Instruction, through the medical society, this subcommittee recommends the recognition of and provision for the 10% of children who have some degree of specific language disability, particularly, in reading (and spelling and writing). Developmental dyslexia (specific reading disability) plays an important role in school dropouts, in delinquency, and even in poverty, but very little is done about its recognition or its remedy in North Carolina.

Other suggestions and recommendations are to be found in the body of our report, but it is felt that these just enumerated are the important ones for the present moment. It should be added that our considerations overlap with those of other medical society committees, such as marriage counselling, maternal health, school health, legislation, etc.

These recommendations were presented, discussed and accepted at the meeting of the Committee on Mental Health and Medicine and Religion held on September 26, 1964.

During the past year with Dr. John L. McCain

(chairman of the mental health committee) as President of the North Carolina Mental Health Association and with Dr. Lloyd Thompson (chairman of the subcommittee) as chairman of the committee on children's services in the NCMHA, the medical society subcommittee report was used as a basis for the "spelling out" of details in the application of the numerous ramifications of children's services at all levels.

This amplification was officially accepted by the NCMHA in December 1964. After this it was thought that the report should be published in separate pamphlet form, but as a joint report of the medical society and the mental health association. Accordingly, this proposition was presented to the Council of the Medical Society of North Carolina on February 7, 1965.

In the meantime the Chairman of the subcommittee corresponded with the Chairman of the committees on maternal health and marriage counseling about the overlapping interests. Moreover, the tentative report was sent to five physicians who are leaders in the field of children's services and prevention at the national level. Their suggestions have been incorporated in the final draft of the report.

The program contained in this joint report is known to the Planning Group of the North Carolina Mental Health Council. It is anticipated that it will be helpful to county medical societies, local mental health associations, other county organizations, and to the comprehensive mental health centers that are being established.

Lloyd J. Thompson, M.D., Chairman

SUBCOMMITTEE ON MEDICINE IN RELIGION

- 1. The Committee urged the local societies to prepare a program in the general area of medicine and religion and this was its major function for the year. A "speakers bureau" consisting of both physicians and ministers was compiled along with audio-visual material available for such programs. At least three such programs were held and others not involving the state committee also were prepared. These generally were throught to be successful but their continuing effect is unknown.
- 2. The Committee participated in the arrangements for the March II and 12, 1965 Physician Leadership Conference and arranged for speaker, Chaplain Robert B. Reeves of Columbia Presbyterian Hospital in New York to be present. The Committee then held a Round-Table Discussion in the field of medicine and religion at that conference at 8:00 a.m. March 12. The resource person in addition to Chaplain Reeves was Mr. Ed Heyd, Chairman of the committee on Program for Hospital Chaplains of the American Hospital Association and hospital administrator from Salisbury, North Carolina.
- 3. The Committee participated in and encouraged the voluntary course offered at UNC School of Medicine on Medicine and Religion dealing with such topics as Euthanasia, contraception, the right to die, psychiatry and religion, etc.
- 4. The Committee attempted to arrange for a speaker at the State Society meeting but because of previously planned program this was not accomplished but may be arranged for the following year perhaps

along with an exhibit in the area of medicine and religion.

5. The Committee believes that the general area of medicine and religion needs general attention and specifically in the area of mental health, physicians and ministers can and shouldwork together to improve the health of the state.

Members:

James B. Alexander, M. D.

Bruce B. Blackmon, M. D.

James R. Dunn, Jr., M. D.

Reverend Orion Hutchinson, Jr. (consultant)

Reverend T. Max Linnes (consultant)

Robert C. Pope, M. D.

Reverend Fred W. Reid, Jr. (consultant)

D. Hilton Seals, M. D.

Dan A. Martin, M.D., Chairman

SUBCOMMITTEE ON PHYSICAN EDUCATION

There continue the ongoing postgraduate educational efforts at Duke, Bowman Gray, and U.N.C. At U.N.C. the two-way radio programs frequently include psychiatric topics. A ten-session, every other week, seminar series is being given annually at Chapel Hill. The State Department of Mental Health continues to support seminars held for local medical groups. Arrangements can be made through Dr. N. E. Stratas, P. O. Box 10217, Raleigh.

Of particular interest is the effort of Dr. James Cathell in his circuit riding consultation-education program in a select number of western counties served by Broughton Hospital. He visits local physicians regularly, consulting with them about discharged Broughton Hospital patients and other psychiatric problems.

Another educational effort which is likely to become important in continuing psychiatric education for physicians is the movement in the direction of developing the unit system throughout the state mental hospitals. With a certain segment of the hospital serving one or two counties, a closer relationship between the hospital personnel and county referring physicians can be expected. This is occurring in Johnston County as its unit has been developed at Dorothea Dix Hospital and with Durham, which has a unit program developing out of John Umstead Hospital.

On February 19 - 21 there will be a weekend training session at the College Inn in Raleigh. Dr. D. A. McLaurin is the Project Director for this program which will include 16 psychiatrists and 16 non-psychiatrist physicians as participants. A weekendlong sensitivity training program is outlined. It will be the beginning of long-range efforts toward bringing psychiatric training closer to local medical practitioners.

C. Vernon, M.D., Chairman

SUBCOMMITTEE ON PUBLIC EDUCATION

Private physicians are over-worked, see very little of their families, and have very little opportunity for recreation. It is not realistic to expact many, if any, county medical society mental health, chairmen to be able to plan, secure, and put on programs in Mental

Health of maximal impact on the varying types of lay groups in the various communities of North Carolina.

The Mental Health sub-committee recommends the formation of a central planning and coordinating group composed of suitable representative from:

North Carolina Medical Society North Carolina Mental Health Association North Carolina Neuro-psychiatric Association Department Public Welfare Department Public Education

This group would be responsible to the North Carolina Mental Health Council and would act in a consultant and advisory capacity to the Education Division of the North Carolina Department of Mental Health.

This sub-committee recommends the immediate necessity to stimulate and recruit suitable young men and women to enter training programs in psychiatric nursing, psychiatric social work, clinical psychology. The need for psychiatrists and adequate psychiatric teaching and training in getting a degree in medicine can not be over-emphasized.

We urge the Society to encourage college counseling services to promote the attractiveness of careers in the Mental Health field, arrange vacation opportunities for work in psychiatric institutions, training schools for the trainable retarded, and schools and summer camps for emotionally disturbed children.

The March 11, 12, 1965 meeting of the County Medical Society Mental Health committee with the annual meeting of the North Carolina Mental Health Association in Raleigh was an unqualified success. It demonstrated a new and exciting way of attracting and educating key people from the whole state including many legislators. The quality of the program brought out so many physicians that an A.M.A. Staff representative present for the occasion, remarked: "How on earth did you get so many physicians to come to a Mental Health Meeting?" John McCain, Charles Llewellyn and the executive staff of the Medical Society did a marvelous job in putting the meeting together. The speakers presented a scientific program for physicians and a separate program for lay people. Future meetings of comparable character should continue to bring out both physicians and the interested public.

A. H. Zealy, Jr., M.D., Chairman

COMMITTEE ON NECROLOGY

The Report of the Committee on Necrology will be given on Sunday evening, May 2, at the Memorial Services, at 8:00 P.M. in the First Presbyterian Church, Charlotte.

The Auxiliary will also participate in this Memorial Service for the deceased physicians and Auxiliary members.

Charles F. Pugh, M.D., Chairman

COMMITTEE ON NEGOTIATIONS

The Negotiating Committee has met informally several times during the past year to discuss problems referred to it by the Medical Society, and a negotiating session was held with the Veterans Administration officials of the State of North Carolina. These included Dr. H. B. Moore, Acting Director, Out-Patient Clinic, VA Regional Office, Mr. H. W. Johnson, Assistant Manager, Regional Office, Mr. H. B. Lewis, Chief of Medical Administration Division, and Mr. Robert Long, Assistant Chief of Medical Administration Division, a member of the Medicare Committee, was also in attendance.

The purpose of the meeting was to set up a uniform procedure and system to handle fees, based on the California Relative Value Study of 1960. This is being negotiated nationally on a state by state basis between the several medical societies and the Veterans Administration.

The fee schedule for out-patient visits of veterans to physicians' offices and the fee schedule for emergency hospitalization of veterans in civilian hospitals was renegotiated on a more satisfactory basis. These areas of negotiation were approved by the Executive Council of the State Medical Society at its mid winder meeting on Sunday, February 7, 1965.

William F. Hollister, M.D., Chairman

NOMINATING COMMITTEE

(Makes report to the First Meeting of the Annual Meeting of the HOUSE OF DELEGATES, Sunday, May 2, 1965,)

COMMITTEE OF PHYSICANS ON NURSING

The Committee of Physicians on Nursing had numerour meetings during the past year. Many problems effecting the nursing profession were considered, and solutions sought for these problems as they effect the medical profession. Certainly, whatever effects fundamental changes in the nursing profession effects the medical profession, more or less. This is inevitable because of the fact that the medical profession and the nursing profession are the two most important groups in the health team of the State and Nation. Along with these problems and proposed changes in the education of nurses and in the image of nursing as a whole have come differences of opinion and misunderstandings between the two professions which have created quite a schism. Therefore, serious consideration needs to be given to these matters for this reason. Your Committee has met several times with representatives from the N. C. State Hospital Association and the State Nurses Association to iron out these misunderstandings, and to asure continued cooperation in matters of health as it applies to patient care in our State. The AMA is giving serious consideration also to the matter of understanding between the two groups on a national basis. A meeting at the national level was held by representatives of the ANA and the

AMA in Williamsburg, Virginia in February 1964. Much was accomplished at this meeting in the way of better understanding between the nursing and medical professions in a changing world in which new patterns in health care are emerging.

The problem which alerted the medical profession to increased activity in the consideration of the changes going on was the fact of the ever increasing shortage of nurses. This situation was brough rather abruptly to the attention of the Medical Society and the Nurses Association during the past few years. During the program of hospital construction under the federal and state bills since 1945 in which an attempt was made to bring the number of beds per 1000 population up to requirements, the matter of increased nursing personnel to take care of those beds in the State and Nation was overlooked. The program of education of nurses lagged. As a result of the shortage of nurses we seem to be rushing rapidly towards a crisis in nursing and patient care in our State. Many Diploma Schools of Nursing have closed over the Nation in the last two or three years, several of which have been in North Carolina. Others are on the brink of closing, for reasons which will be stated below.

The Ray Brown Report of 1964 on the Survey of Nursing Education in North Carolina stimulated serious concern and study in our State. This report, which was sponsored by the N. C. Board of Higher Education and the Medical Care Commission, was very complete and came up with eight specific recommendations for the education of nurses in our State.

In the first place the report recommended that nursing education be administered by the State Board of Education. Two courses were recommended - the Associate Degree of two years and the Baccalaureate Degree of four years. The courses were to be given on the campuses of the community colleges and the major colleges of the State. Training in basic sciences, sociology, etc., is to be given on the college campus. The student nurses would live under the same conditions with scheduled courses, hours, etc., as students in other departments. The practical or bedside work is to be given in hospitals affiliated with the colleges. Both courses would lead to the RN Degree. Both courses have been in operation in a number of states and seem to be working very well.

The matter of chief concern as far as the medical profession is concerned at the present is the fate of the Diploma or Hospital Schools of Nursing, which in the past have produced 92% of our nurses. The Diploma School, although it was mentioned in the Brown Report, was not taken care of on a state tax supported basis. No recommendation was made for this. The same is true in the GUIDELINES, published by the State Nurses Association in connection with the recommendations for the future training of nurses. In fact, their report was very discouraging as far as the Diploma Schools are concerned, and suggested that most, if not all, of the Diploma Schools should be discontinued by 1970.

At the present time the Diploma Schools of Nursing in North Carolina rate right at the bottom among the states in the Nation as far as accreditation is con-

cerned. The Schools in only two or three states rate lower than ours. This, notwithstanding the fact that during the last 25 or 30 years these Schools have been upgraded and improved as far as their curriculum and their facilities are concerned. This, of course, was done not only to improve the quality of nursing, but also to meet accreditation by the NLN. The requirements for this have gradually gone beyond the reach of the hospitals. The Accreditation Board is the NLN, and this Organization also seems to feel that the day of the Diploma Schools of Nursing is past.

The upgrading of the Diploma Schools has gone to such an extent that the classroom work has replaced to a large extent the bedside nursing that was formerly expected of the student nurse. This poses a real economic problem for the Hospital because of necessity they must hire more nursing personnel to give adequate patient care. It is figured that the average cost of training a nurse is around \$2400.00 a year. As it stands now, the Hospitals stand to loose about \$1200.00 to \$1400.00 a year on each nurse trained. This expense, of course, must be passed on to the patient and increases hospital costs to the public. Furthermore, the Diploma Schools are stigmatized, more or less, as a result of lack of accreditation. The student nurses are being influenced more and more by the desire to take the new courses on the college campus basis. Therefore, recruitment to the Diploma Schools is rapidly decreasing.

At the present time four Schools of Nursing in North Carolina are accredited. Under the proposed changes in education in the field of nursing, no doubt a few Diploma or Hospital Schools will survive. It will be necessary for them to tie in with the colleges which are close at hand, and to be subsidized with either state or private funds.

The thing that concerns the medical profession chiefly is the interim between the establishment of the Associate and Baccalaureate Degree programs and the discontinuance of the Hospital Schools. It is the feeling of our group, the hospital people, most of the nurses over the State apparently, and the public at large that these Diploma Schools should be immediately upgraded and supported by tax funds so that they can meet accreditation for at least ten years yet. Otherwise, it is felt that a real crisis in the field of nursing and patient care will develop. The Associate Degree and Baccalaureate Degree will have to be started and the fact that they are able to produce enough nurses before we can risk having the Diploma Schools discontinued.

Let me say that our Committee and, I believe, the medical profession generally favor the development of the Associate and Baccalaureate Degrees in nursing, and the administration of these courses by the State Board of Education. Furthermore, I am sure that the medical profession will give it complete support as a tax supported institution. We believe firmly that nursing education has been the red headed step-daughter in the educational program in North Carolina for too long already. Nursing education deserves state support just as much, if not more so, than other departments of education such as engineering, medicine, law, etc. Let me repeat that we are concerned with the time element and the danger of a real crisis

during the interim between the establishment of the college course and the discontinuance of the Hospital Schools.

The Schools for the training of Licensed Practical Nurses in North Carolina are under the direction of the State Board of Education and administered effectively. The growth of the Schools for the LPN has been phenomenal. Had it not been for LPN's and the nurses' aides, a crisis in patient care in North Carolina would have developed several years ago. The LPN, however, cannot possibly take the place of the RN. The shortage of RN's will increase and become critical regardless of whatever other personel is added. This comes about, of course. as a result of the changing patters in nursing. More and more the RN has had to sacrifice the real services for which she was trained and wants to do, bedside nursing, in favor of clerical work in connection with the records of the patients. Furthermore, on account of 'he fact that the doctor is so busy this day and time with trying to keep up with scientific and technological developments and increased practice, that he has had to turn many of the procedures that he formerly took care of over to the nurse. In the smaller Hospitals, at least, she gives the intravenous infusions and transfusions, and operates much of the technical mechanical equipment that is necessary in the care of the patient at the present time.

At the present time a bill is being prepared by the N. C. Hospital Association and co-sponsored by the medical profession to be presented to the State Legislature asking for State aid for the Diploma Schools of Nursing. The bill has not been completed yet, and, therefore, is not available, but it is to be presented to the Legislature at this session. This will make it possible, if passed, for the D.ploma Schools to continue, temporarily at least, by upgrading to the point where they can be accredited. This bill would have the strong support of the Hospital Association, by the Medical Society, and I hope by the State Nurses Association, most of the members of which have been trained in the Diploma Schools, and by the public in general. We have the assurance also of the blessing of the State Board of Higher Education, although they have not promised support of the bill.

I might mention also that the Committee of Physicians on Nursing has had under serious consideration with the nursing groups, the matter of certain changes being made by the Nurses Association in the Nurses Practice Act. Most of the changes suggested and the differences in opinion between the Medical Society and the Nurses Association have been ironed out. These points related to the Mandatory Practice Act and the selection of members to the Nurses Board of Education and Examiners. The recommendation of the medical profession is that the selection of the Board of Examiners be left as previously to the Governor, and that the doctor members be retained on the Board. These matters have been agreed to.

As a result of the meetings of the Committee of Physicians on Nursing with representatives of the other health groups in our State much good has been accomplished. The frank discussions have resulted in much better understanding and cooperative effort in solving the problems of nursing education in our State. The medical profession in North Carolina is proud of the spirit of progress which is being shown by the nursing profession, and is anxious to give support to their program directed towards higher standards of nursing education in North Carolina.

I would like to end this report with a final paragraph taken from the report on the OBJECTIVES AND PROGRAM OF THE AMA COMMITTEE ON NURSING which is as follows: "If the medical and nursing professions are to make the fullest use of their joint potential, they must have not only a common denominator of interest in the patient and a comparable body of knowledge, but also the kind of relationship that derives from a deeper appreciation of, and respect for, each other as allies working toward the same goals."

Finally, I want to thank the members of the Committee of Physicians on Nursing for the cooperation and grand support which they have given me in the work of the Committee during the past year. They have shown unuaual dedication in this work. I wish to mention particularly the work of the Sub-Committee, headed by Dr. Harry Brockman, for its fine work in reviewing and making recommendations on the Brown Report and the Guidelines. Also, I wish to thank Jim Barnes and Kay Ziegler for their fine cooperation in arranging for meetings and reports of the Committee. We have worked closely with Dr. Ed Beddingfield, Chairman of the Legislative Committee, during the year. He has met with us several times and has given valuable advice and assistance in the solution of the problems at hand. Of course, we also had the advantage of the advice and cooperation of John Anderson, Jr., the attorney for the Society.

But, we are more concerned with the medical legislation providing support for an indefinite period for our diploma schools. In this way, we can feel assured of the training of practical bedside nurses. The Committee on Nursing is dedicated for the support of this legislation.

Fred C. Hubbard, M.D., Chairman

SUBCOMMITTEE ON NURSING AND PATIENT CARE

The N. C. Committee on Nursing and Patient Care is a newly formed committee developed as an amalgamation of two previously formed committees concerned with nursing and patient care.

Organized in 1960, the N. C. Committee on Nursing and Patient Care, is a quasi-official, coordinating agency for major health groups in the state, both governmental and voluntary, which meets quarterly. The Committee is composed of ten representatives from statewide health organizations and eleven public members. Principle objective of the Committee is "to concern itself with the activities involved in providing better patient care in N. C. and to afford a medium for liaison between the three groups primarily and directly responsible for caring for the sick, namely, physicians, nurses and hospital administrators."

Under the leadership of Mr. H. C. Cranford, Jr., Chairman, the year 1964-1965 has been a most active one with many projects completed and new ones undertaken.

1) Joint Statement of Purpose

The major health disciplines in N. C. approved a Joint Statement of Purpose which recognizes the improved patient care as their primary mutual objective. The objectives of the committee, approved in the Joint Statement are as follows:

- A) To encourage and cooperate in the continuing improvement of patient care through the establishment and operation of a Patient Care Committee in every hospital.
- b) To encourage the invitation of nursing supervisors to attend clinical staff conferences.
- c) To encourage supervisors of other allied departments to attend scientific meetings.
- d) To encourage full interchange of representatives of the major health disciplines at regional, state and national hospital and medical conferences.
- e) To encourage exchange of views on matters of mutual concern through publications of the interested groups.
- f) To endeavor to bring about a united presentation to the public of mutual health problems.
 - 2) Joint Statement of Hospital Visitation

The Committee this year became concerned with the misuse of hospital visiting. It was felt that the abuse of patient visiting very frequently outways the therapeutic advantages. The seriousness of the situation was felt of sufficient significance that positive and united action is required. Believing that the citizens of N. C., when aware of the harmful effects of improper visiting, will cooperate to insure the speedy recovery of their loved ones, a Joint Statement of Purpose regarding visitation was adopted by the three major health agencies in N. C. In the agreement, it was decided to individually and jointly sponsor a program to provide an understanding of the need for the acceptance of proper visiting controls. Through assistance from the Duke Endowment, a student in the hospital administration course at Duke University was assigned to work with Dr. Robert Cadmus of the Department of Hospital Administration at the University of N.C. to review the visitation problem in N. C. and submit a proposal for a method of continuing further study and implementing action to improve the hospital visitation situation.

3) Health Identification Cards

A program to encourage the citizens of N. C. to carry personal health identification cards was made by this Committee. The Medical Society of the State of N. C. has available these health identification cards for distribution in bulk to professional and lay groups for distribution to individuals. Groups and individuals across the state were urged to promote the use of these cards.

4) "I Am Your Patient" Brochure

The brochure "I Am Your Patient" is a leaflet which describes receiving health services through the eyes of a patient and was promoted for use in hospitals and clinics across the state. It was exceptionally well received with additional printing of this leaflet being required to meet the requests for copies.

The Programs for the four quarterly meetings have been concerned with:

1) Prepayment as a means of meeting the rising cost of hospital care.

- 2) Report and recommendations of the Committee on the study of education for nursing in N. C. "Guidelines for Nursing Education in N. C."
- Report of the Survey of Nursing Education in N. C. by Ray E. Brown.
- 4) Program on proposed health legislation to be presented by the three major health disciplines to the N. C. General Assembly.

John L. McCain, M.D., Secretary

COMMITTEE ADVISORY TO MARRIAGE COUNSELING

The Committee on Marriage Counselling met at the home of Dr. Rachel Davis of Kinston on August 1 & 2, 1964, and made the following proposals or suggestions:

That we define marriage counselling as the art and science of assisting patients through counselling to gain the greatest possible fulfillment of their marriage, which includes education in the family circle, through schools, and pre-maritally.

That the function of the committee be:

- 1. To sponsor symposia or postgraduate programs for practicing physicians in marriage counselling using the potentials of the medical schools of the state. Also, to encourage physicians in setting up mental health programs, using ancillary groups, etc., to fulfill their role in the community.
- 2. To arrange definitive programs to be given during the state medical society meeting in the area of marriage counselling.
- 3. To provide a list of possible speakers for medical societies for programs on marriage counselling.
- 4. To encourage the cooperation of the North Carolina Academy of General Practice to organize a marriage counselling committee to work with this committee for the furtherance of this program.

The committee discussed the possibility of contacting and visiting schools of marriage counselling for further study and information, also, to inquire as to the best methods of instruction in family life to be used in public schools.

The Committee met again on September 26, 1964, during the Committee Conclave at Mid Pines.

Attention was called to the publication by the UNC Press of a book "Marriage Counselling in Medical Practice" which pointed up the dire lack of training and practical application in medical practice.

Dr. Eugene Linton said that probably two or three hundred physicians would attend a well-organized symposium with well-known and qualified speakers and said that he had tentative arrangements for financial help from a pharmaceutical company. The Chairman asked Dr. Linton to work with Harvard and Bowman Gray groups to try to set up the proposed symposium in late May 1965. Mr. Barnes said that very limited funds were available for speakers at the Annual Meeting of the Medical Society and program at the state meeting in May 1965 in Charlotte.

Dr. Breslin called attention to a project underway at UNC that might help penpoint needs and resources and Mr. Barnes called attention to a current mental health questionnaire among physicians, which results might be of interest to the Committee.

Dr. Linton outlined the "Family Life" lecture pro-

gram for Junior and Senior medical students at Bowman Gray.

Mr. Barnes said that a talk by Dr. Woods on Planned Parenthood and the Population Explosion had gone over very well at the New Hanover Symposium and Dr. Woods was scheduled tentatively to be on the program at the next state meeting of the Medical Society. Dr. Wilson suggested the possibility of utilizing the various N. C. Symposia for display of an exhibit if one could be devised or secured through a drug company.

Since the meeting at Mid Pines I have met with the North Carolina Group of Social Workers, Gynecologist and Psychiatrists who are interested in Marital Counselling. This meeting was held in Chapel Hill. Dr. Frank Lock of the Department of OB-Gyn, Bowman Gray Medical School presided.

It was the consensus of this group that there are many groups in North Carolina interested in this problem of marital counselling, that it is of paramount importance to our entire Society. It was also pointed out that maybe the most effective program in the state could come from good cooperation and communication between all interested groups. At this meeting Dr. Eugene B. Linton of the Bowman Gray Department of OBGYN reported on plans for a seminar to be held in the latter part of May. This seminar is to be one of the most outstanding, if not the most outstanding, educational meetings in Marital Counselling ever held in North Carolina. Invitations have been issued to other organizations other than the Medical Society who are interested in this field and particularly to the Obstetricians and Gynecologists of the State and to the General Practitioners.

On February 23rd I was accompanied by Dr. Ethel Nash of the Department of Obstetrics and Gynecology of Bowman Gray to meet with the Counselling Service in Marriage and Family Life under the auspices of the Protestant Episcopal Church Dioceses of North Carolina, Department of Christian Social Relations.

At the meeting of the Western North Carolina Diocese of Episcopal Church which was held at Highlands Hospital, the attendance and interest were excellent. Dr. Nash gave an extraordinarily fine concept of Marital Counselling and I gave, what I believe to be, the present feeling of the committee of the State Medical Society. The consensus of opinions gathered from this meeting was that there should be a co-ordinating body in North Carolina of people interested in Marital Counselling and Pre-Marital Education. The membership of this body should include representation from each interested group. That this body should act as a clearing house for all groups and should act as a source of information for materials and people interested in this area particularly for programs and for further education of all peoples in the state interested in this great challenging prob-

I have vied the available marital counselling material with members of the Department of Psychiatry of the University of North Carolina. It was the consensus of opinion of the people who viewed this audio-visual material that this material was not of adequate maturity and concept to be used in our program. That it would probably be good for lay organizations but not

for teaching material for professional groups.

As a result of the viewing of the available educational films the Department of Psychiatry headed by Dr. Marianne S. Breslin has committed themselves to producing a film at the University for the Committee on Marital Counselling of the State Medical Society.

We have made contact with the Academy of General Practice in the State of which Dr. Robert Shackelford of Mount Olive is President. The Academy of General Practice of this State has included Marital Counselling as a major part of their program for the years 1964, 1965. They are having area meetings and calling on such people as Dr. Ethel Nash who has been teaching marital counselling at Bowman Gray for eight years.

The plans for the State Meeting in Charlotte are to have Dr. H. Curtis Wood, Medical Field Consultant, Human Betterment Association to speak to us at a Breakfast on Tuesday morning on the Necessity of Family Planning in Counselling. He will be a major speaker at the Tuesday morning General Session and a guest speaker for the Section on Obstetrics & Gynecology on Monday afternoon.

The members of the committee feel that we have made tangible progress and have come up with a workable program for further education in the area of marital counselling.

It is also our feeling that there should be a greater educational program to all peoples, telling them of the progress being made by the Medical Profession and like interested groups in this area and telling them of the greater availability of help in this area among the physicians of North Carolina.

Rachel D. Davis, M.D., Chairman

COMMITTEE ON OCCUPATIONAL HEALTH

This Committee met September 27, 1964, at the Mid Pines Club at Southern Pines. Considerable time was spent discussing an Occupational Health Program for State employees. It was agreed to work closely with the Governor's Council and the N. C. Health Council in developing such a program.

There was also a discussion of screening examinations to be offered to those attending the State Medical Society meeting in May. This program is till in the developmental stage due to some delay in acquiring analytical equipment.

Another meeting of the Committee was held February 9 in Greensboro in conjunction with representatives from the N. C. Health Council and the Governor's Council on Occupational Health. This meeting was an effort to finalize the planning for the State Employees program. Another meeting of a sub-committee will be held in Winston-Salem on March 5 and 6 for the

Committee on Occupational Health continued

Another meeting of the Committee was held February 9 in Greensboro in conjunction with representatives from the N. C. Health Council and the Governor's Council on Occupational Health. This meeting was an effort to finalize the planning for the State Employees program. Another meeting of a sub-committee will be held in Winston-Salem on March 5 and 6 for the

final drafting of the program.

In an effort to stimulate more activity in County Medical Societies, a letter and 2 reprints was sent to all Chairmen of County Occupational Health Committees. Chairmen were urged to present the letter to a full meeting of the County Society and to request more reprints as they could be used.

B. W. Goodman, M.D., Chairman

COMMITTEE ON PHYSICAL REHABILITATION

The Committee on Physical Rehabilitation met on Saturday, September 26, 1964, at 9:00 a.m. in Room #1 at Mid Pines Club, Pinehurst, North Carolina. Five members were present. Four were absent.

The following changes in the Vocational Rehabilitation personnel as of July 1, 1964, were enumerated:

- 1. Mr. Robert A. Lassiter replaced Col. Charles H. Warren as State Director.
- 2. Dr. L. L. Schurter replaced Dr. Hugh A. Thompson as Medical Advisor.

Reports of services rendered, client breakdown, and expenditures by the Vocational Rehabilitation Department were heard by the Committee. Closer liaison and more detailed information of all statistics from the Department of Vocational Rehabilitation was expressed as desirable.

Employment of the physically handicapped was urged by the Committee and candidates for Physicians Award of the President's Committee on Employment of the Handicapped were discussed. One, Dr. Jacob H. Shuford was nominated.

In view of the continued dissatisfaction on the part of physicians, clients, and other personnel in limb fitting of the amputee and instructions in its use, the Committee felt that the establishment of certain centers for this purpose in various sections of the state was in order. Accordingly, a sub-committee was appointed to study this problem, canvas the profession for physicians interested in helping at such centers, and report back to the Committee in September, 1964, with their recommendations. In this connection, funds were requested from the State Society for a joint meeting of the Director of Physical Rehabilitation, the Chairman of this Committee, and representatives from the Amputation Sub-committee.

Interim patient care between general hospital and home was discussed, both for the elderly and others. The need for insurance coverage for this type patient was stressed. The committee encouraged Hospital Care to set up criteria for nursing homes providing convalescent and rehabilitation services, and to accept these licensed nursing homes.

Walter S. Hunt, M.D., Chairman

COMMITTEE LIAISON TO NORTH CAROLINA PHARMACY ASSOCIATION

The Committee has been actively engaged throughout the year, in cooperation with a similar group from the N. C. Pharmaceutical Association, as an advisory group to the State Board of Public Welfare in its Kerr-Mills Drug Program. The Drug Pro-

gram is now in operation and we hope to continue to assist in improving its operation.

In addition to this function, the Committee jointly sponsored the N. C. Congress on Medicine and Pharmacy in November 1964 at the Jack Tar Hotel in Durham, North Carolina. Outstanding speakers from both professions were heard in the one and one half day meeting. It was felt by all concerned that the meeting was very worthwhile.

There are many areas in which joint consideration of mutual problems will be of benefit to the professions of medicine and pharmacy. The Kerr-Mills Drug Program is but one example, and many others exist. This Committee hopes to strengthen its ties with the pharmacy leadership in order that we might work together for our mutual benefit and greater service to our patients.

John T. Dees, M.D., Chairman

REPORT OF THE BOARD OF MEDICAL EXAMINERS STATISTICS

November 1, 1963 - October 31, 1964

Total number applicants granted license By written examination By endorsement of credentials	359 188 171
Limited license Hospital residents County or counties State institutions	94 82 12 0
Special limited license Hospital residents Postgraduate foreign exchange residents Staff state institutions	94 53 36 5
Written examination failure	6
Applicants rejected license by endorsement of credentials	0
Applicants declined permission to take written examination	0
Hearings Narcotic addiction Surveillance as to narcotic addiction Alleged prescribing of narcotics Alleged prescribing of barbiturates Alcoholism Conviction of felony in another state Adjudication of mental incompetency Delegation in regard to licensure of foreign medical graduate Indictment Federal Court in regard to income tax Petition for reinstatement narcotic tax stamp	17 5 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Investigation State Bureau of Investigation Alleged violation state law prescribing barbiturates Alleged excess prescribing narcotic drug Narcotic addiction	4

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ADVISORY TO THE NORTH CAROLINA LICENSED PRACTICAL NURSES ASSOCIATION

A joint meeting of the Executive Board of the North Carolina Licensed Practical Nurses Association and its Advisory Council was held on November 12, 1964, in Durham. I attended the meeting as an advisor from the Medical Society of the State of North Carolina. Advisors from the State Nursing Association. The State Board of Health, and The Hospital Association were also in attendance. Members of the Executive Board reviewed the activities of the Practical Nurses Association and outlined plans for future activities particularly in the field of recruitment and continuing education for the licensed practical nurse. The Advisory Board was unanimous in its support of the plans of the Association and encouraged them to continue their efforts to improve the methods of both pre and postgraduate training for practical nurses. No requests were made for support or approval by the Medical Society of the State of North Carolina of any matters of policy.

> Jack Hughes, M. D. Advisor to North Carolina Practical Nurses Association

COMMITTEE ON ASSOCIATION OF PROFESSIONS

The North Carolina Association of Professions has been officially organized and functioning for two years. During the past year, a fifth group joined, the North Carolina Pharmaceutical Association, and membership opened to individual members of the five state professional organizations, namely; The Medical Society of the State of North Carolina; North Carolina Professional Engineers; North Carolina Chapter, The American Institute of Architects; North Carolina Veterinary Medical Association, and now, the North Carolina Pharmaceutical Association.

Officers elected at the first annual meeting, March 1964 to serve for the past year were: President: John R. Kernodle, M. D.; Vice-President, Earl L. Knox, DVM; Secretary, William W. Dodge, III, A.I.A. and Treasurer, Robert G. Bourne, P. E. Annette S. Boutwell of Raleigh serves as Executive Secretary.

Each member organization has equal representation on the Board of Directors, six members. Last year, the Board approved having Consultants from the medical society districts as a means of creating awareness and individual participation of physicians. The consultants appointed to serve were: Thomas P. Nash, III, M. D. Elizabeth City; Flemming Fuller, M. D. Kinston; Dewey Bridger, M. D. Bladenboro; Fred William Payne, Jr. M. D. Rocky Mount; Jack E. Mohr, M. D. Lumberton; David G. Welton, M. D. Charlotte; and Walter Tice, M. D. High Point.

The members of the Board of Directors representing the Medical Society for 1964-65 are: Alfred T. Hamilton; M. D.; John Carl Hamrick, M. D. Shelby; John S. Rhodes, M. D. Raleigh; John R. Kernodle, M. D. Burlington; George G. Gilbert, M. D. Asheville; and Thomas G. Thurston, M. D. of Salisbury. For 1965, three new Board members will be appointed for a two-year period, 1965-66 and three will continue serving a one-year appointment for 1965. First Annual Meeting held in Burlington, N. C. March 14, 1964

Senator B. Everett Jordan and Hugh W. Brenneman of Michigan were the guest speakers for the First Annual Meeting held in Burlington, Both speakers encouraged the further promotion of the Association of Professions as such an organization was greatly needed in North Carolina. The North Carolina Pharmaceutical Association was accepted as a member organization. The question of Individual Membership was presented and approved by the Board of Directors. It was agreed that any member of a state professional member organization could become an individual member of the Association. A Membership Fee of \$5.00 per year was set for individual membership. Membership Campaign launched in 1964. Results of the individual membership campaign show: 67 physicians; 30 veterinarians; 18 professional engineers; architects: and 155 pharmacists. A total of 276 members. Efforts by the state member organizations to gain individual membership will be stepped up in 1965 in hopes of having 500 members by the end of the year.

The Board of Directors held quarterly meetings during the year. In March 1964 the Board met following the First Annual Meeting. In September, the Board joined with the State Medical Society in Pinehurst and had Martin P. Hines, DVM, State Board of Health as guest speaker. In December, the Board met in Chapel Hill at the N. C. Pharmaceutical Association Building and had a panel discussion on pertinent legislation being considered by the State Member groups.

Dr. E. T. Beddingfield spoke for medicine; Robert G. Bourne spoke for the professional engineers; W. J. Smith spoke on behalf of the pharmacists; and Earl L. Knox, DVM spoke on behalf of veternarians. William Dodge and Albert Haskins spoke on behalf of the architects. The purpose of this meeting was to acquaint all member groups with items of state and national legislation which was of concern and interest to each respective group.

The Board of Directors will meet in Raleigh on March 24th during the Second Annual Meeting. New

officers will be elected for 1965 and new members of the Board of Directors will be installed. Members of the Board are appointed by the State Organization and are staggered terms. Three members elected for two years and three members for one year.

Exhibit prepared for the Association of Professions; An exhibit was prepared in 1964 and has been used by each of the member groups at selected meetings. The exhibit has been used as promotion for the individual membership campaign and to acquaint professional leaders with the purposes and objectives of the Association of Professions. The exhibit is on loan to any member group upon request.

Second Annual Meeting Planned for March 24, 1965 in Raleigh:

An all-out effort is being made to launch the Association of Professions as an effective organization by the program scheduled to be held in Raleigh on Wednesday, March 24th. Governor Dan K. Moore will be the luncheon speaker and members of the General Assembly will be guests of the Association for the day's program.

The program committee was fortunate in getting top level speakers representing each of the member professional groups. These are: Dr. Ralph Fadum, P. E. Dean of Engineering, North Carolina State University at Raleigh; Austin Smith, President, Pharmaceutical Manufacturers Association, Washington, D. C.; Leslie N. Boney, A.I.A. President of the North Carolina Chapter, American Institute of Architects; Don Spangler, DVM President-elect, American Veternary Medical Association; and Aubrey D. Gates, Director of Field Services, American Medical Association, Chicago, Illinois. The Theme of the Annual Meeting is: Inter-Relationships Between the Professions." Attendance of some 300--400 people is expected.

Summary: The major purpose of the Association of Professions will continue to provide a "forum" and organizational machinery whereby the combined strength and counsel of all professionals can be utilized for the advancement of professional ideas and the promotion of professional leadership.

The close relationships between members of the professions brings into focus a better understanding and appreciation of one another, so that the best of the professional training, standards of practice, and service to the public can be maintained and upheld for future practitioners.

John R. Kernodle, M.D., President

COMMITTEE ON PUBLIC RELATIONS

The annual committee meeting was held on Thursday, September 24, 1964, at Mid Pines, Southern Pines, North Carolina with eight members present.

The following decisions were made:

- 1. Continued support of the Information Booth at North Carolina State Fair at Raleigh both for 1964 and 1965.
- 2. Appropriated \$100 to North Carolina Academy of Science in support of the High School Science project. Continue to invite one high school science fair exhibitor to the Annual Medical Society Meeting

to be held this year in Charlotte.

- 3. Continued support of Today's Health Magazine to members of the General Assembly and certain other designated state officials. To support a one year subscription to the libraries of all junior and senior colleges in North Carolina and at the end of the one-year period, this program to the libraries be re-evaluated.
- $\mathbf{4.}$ Supported the AMA and their advertising program concerning legislation.
- 5. Discussed the annual Conference of Officers and Committeemen. (Report below)
- 6. Approved a Speech Training Session, (Report below)

On December 4-5 at the Jack Tar in Durham, 23 selected state officers and leaders attended a Speech Training Session sponsored by Smith, Kline and French Laboratories. Those who participated felt that much benefit was achieved from the instruction and work sessions. We hope that this can be repeated in the future.

The annual Conference of County Medical Society Officers and Committeemen was held at Pinehurst, February 5-6, 1965. Friday evening was devoted to an instruction session for newly elected presidents and secretaries, and I am happy to report that an overflow crowd presented itself for this dinner meeting. Saturday, February 6 was devoted to legislation and panel discussions on "THE FREEDOM OF MEDICINE". With a total registration of 165 there were 99 doctors representing 45 county societies attending this conference. A guide for secretaries was compiled and distributed to the secretaries present. This will be revised in a better form so that each new secretary can obtain one upon assuming his office.

Your Chairman attended the Annual AMA Institute on Public Relations held in Chicago during August and this continues to be one of the most instructive programs offered.

The Health Fair held at Durham last year under the sponsorship of the Durham-Orange County Society was most successful and we look forward to other Health Fairs being held throughout the State.

Our thanks to Bill Hilliard, assistant Executive Director for his continued excellence in his work for the State Society and particularly for the Public Relations Bulletin which keeps our members aware of all matters pertaining to state and national medicine.

Phillip Naumoff, M.D., Chairman

COMMITTEE ON RADIATION

The Committee on Radiation of the Medical Society of North Carolina has nothing to report. There are no radiation problems. Isotopes and radiation protection, as set up under the State Board of Health, is being well taken care of by Dr. Wilson and we have had no radiation problems as of to date.

Robert J. Reeves, M.D., Chairman

7 1 123

RETIREMENT SAVINGS PLAN COMMITTEE

During 1964 implementation of the proposed North Carolina Medical Retirement Savings Plan continued to be postponed pending the solution of several problems connected with the duties of the trustee. However, in the fall of 1964 these technicalities were apparently resolved and Wachovia Bank and Trust Company proceded with preparations and we are now in the final stages to begin operation of the Savings Plan.

The Retirement Savings Plan Committee met on September 24, 1964, at the Mid Pines Club, Southern Pines, North Carolina, at which time trust officers of the Wachovia Bank and Trust Company reported that procedures had been worked out to have to proposed plan approved by both federal and state agencies.

Also reported for information was that a number of other institutions and societies had contacted this Society and had invited them to participate in their particular plan.

Following adjournment of the meeting a 25 minute color sound film on the AMA members Retirement Plan was shown.

Wachovia has been making progress in developing the forms and instructions for joining the Retirement Savings Plan. It will be necessary for attorneys on both sides to examine the completed instruments following which they will be submitted to the federal and state authorities for approval.

Meanwhile, several changes have occurred requiring alteration of the insured annuity portion of the plan and these are being considered by all concerned.

The Committee wishes to reiterate that it does not propose to the Society that the North Carolina Retirement Savings Plan be put in operation unless it can be definitely shown to be a plan in which members of this Society may obtain certain advantages they otherwise could not obtain.

Unless there is some unforseen circumstance in all probability the North Carolina Medical Retirement Savings Plan will be open for operation during 1965.

Jesse Caldwell, M.D., Chairman

COMMITTEE ON RURAL HEALTH

The Committee on Rural Health met with its Advisory Committee in Raleigh in March, 1964, at which time past activities of the Committee was reviewed and future plans were discussed. It was felt that the following new programs or continuing programs should be carried out:

- 1. Continuing encouragement of our young people in health matters by (a) sponsoring one trip to the National 4-H Club Congress for the state health winner, and (b) providing certificates for the 4-H King and Queen of each county with a complimentary copy of Today's Health to their high school library.
- 2. To continue close liason with major agricultural organizations such as Extension Services, Farm Bureau, Grange, and 4-H Clubs.

- 3. Continued participation in the North Carolina Rural Safety Council.
- 4. Continue Advisory Committee and hold at least one joint meeting a year to assist in planning major activities.
- Continue emphasis for Tetanus Toxoid immunizations.
- 6. Urge more active interest by all concerned in Tuberculosis.

At this meeting a statement prepared by the chairman of the committee entitled "Concepts of Rural Health" was read, and this article appeared later in the May, 1964 issue of The Journal of the North Carolina Medical Society. Copies of this article prepared by the AMA Council on Rural Health were distributed at the 1964 conference of the Women's Auxiliary of the American Medical Association, October 4 - 7, in Chicago, the AMA Council Members on Rural Health and the State Committee Chairman of the Medical Society. The Chairman of the Committee attended the AMA Council on Rural Health meeting in Columbus, Ohio in March, 1964.

On August 30, 1964, the State Medical Society Committee on Rural Health held a joint meeting with the Rural Health Committee of the North Carolina Academy of General Practice. At this meeting many of the aspects of the problems of rural health were discussed. Polia immunization which was been carred out was discussed. The following recommendations which were later presented to the Executive Committee of the State Medical Society were made.

- 1. That Immunization for Tetanus and Diphtheria injection throughout the school years be continued on a booster basis.
- 2. To carry out the recommendation of the Surgeon General's Task Force and the Governor's Committee on Tuberculosis with regard to skin testing in school children in the state.
- 3. To urge that knowledge concerning pond safety be disseminated throughout the state and the effort be made toward encouraging better farm pond safety.
- 4. It was recommended that Agricultural poisons be plainly labeled with a tear-off label that would contain antidotes which could be carried to the physician along with the patient that had been poisoned.

In addition to this, problems of air polution, water and sewage disposal were discussed.

There is now in the planning stage a statewide conference on rural Health which it is hoped will be held in the latter part of the summer.

Edward L. Boyette, M.D., Chairman

COMMITTEE ON SCHOOL HEALTH AND STATE COORDINATING SERVICE

Due to the untimely death in June 1964, of the Chairman of the School Health Committee, Frank E. Barnes, M. C., the President appointed D. A. Mc-Laurin, M. D., to fill the unexpired term. The Committee suffered a great loss with Dr. Barnes, particularly in his active interest in the Medical Aspects of Sports. He was vice-president of the American College of Sports Medicine and an ex-officio member of the Board of Directors of the American Associa-

tion for Automotive Medicine. Dr. Barnes also attended the 9th National Conference on Physicians and

Schools, Chicago, 1963.

The Committee cooperated with the N. C. Academy of General Practice and the Cancer Control Program, Atlanta, Georgia, in the production of a "SHOP TALK" on Athletic Injuries. "SHOP TALK" is a film strip and accompanying tape recording of physicians discussing athletic injuries. Intent of "SHOP TALK" is to stimulate discussion by the viewing group. A trained moderator leads discussion.

The Committee also participated in a Seminar on Medical Aspects of Sports in Chapel Hill, N. C., on

May 14, 1964.

In August 1964, the participants in the Coaching Clinic were urged by members of the committee to seek more practice time prior to the opening of the football competition schedule as well as spring practice. Current regulations ban practice until August 15, or two weeks before the opening of school.

On September 24, 1964, the Committee held its first regular (conclave) meeting of the year and the attached agenda attests several items of consideration upon which it has subsequently been active. At that time, the Committee met with representatives of the N. C. High School Athletic Association and representatives of the Department of Public Instruction with the latter two groups agreeing to propose to their groups the committee's recommendation that the present August 15 date be retained for the opening of football practice but the first game would not take place until the Friday after Labor Day and the first three days should be non-contact.

The Committee also encourages only one practice session daily and the avoidance of the heat of the day

for practice.

Efforts are being made by the Committee to seek the expansion of the present health, and physical education program in N. C. to require it the full twelve years for both boys and girls. For several years, a survey on athletic injuries has been made by the Committee. Those schools participating in the study have been most cooperative. Results are coded by the State Board of Health's IBM System.

A representative of the Committee and members of the Staff attended the Sixth Annual Conference on Medical Aspects of Sports, December, 1964, Miami

Beach.

Efforts have been concentrated with other medically oriented groups to establish an Advisory Council on the administration of School Health Programs in N. C. Dr. McLaurin, Dr. Keleher, Dr. Scureltis, Dr. George Paschal, President-Elect of the Medical Society, Mr. James T. Barnes, and a representative of the State Dental Society met with Governor Dan K. Moore on February 9, 1965, to discuss the appointment of this advisory group.

The Committee continues to concentrate its efforts

- 1. Encouraging sex education in the public school system.
- 2. Recommending tuberculin skin testing prior to entering school and again at age 14. A waiver provision not to require repeat testing of known positive reactors.

- 3. Continuation of diphtheria and tetanus immunization at four year intervals throughout the school career.
- Recommending small pox be administered concurrently every fourth year.
- 5. Suggesting county medical societies seek to implement a program of pre-school clinics.

D. A. McLaurin, M.D., Chairman

COMMITTEE ADVISORY TO STUDENT A. M. A. CHAPTERS IN NORTH CAROLINA

Persuant to the Committees' design as reported 1 March 1964; to enhance and increase student participation in the State Medical Society Affairs Committee work in Pinehurst, 16 September 1964, and several sessions among SAMA presidents, one or members of the above committee laid ground work, hopefully for a larger and better student session in Charlotte this year.

For the first time, The Section of the Student A.M.A. Chapters of the N.C. Medical Society organized for 3 May 1965 will begin at 3 P.M. and for one hour there will be a symposium of treatment of hypertension. A second hour will be devoted to papers presented by students from Bowman Gray, Duke and U.N.C. Then there will be a social hour and dinner with Dr. George Paschal, Jr., guest speaker, and the awarding of a prize for the outstanding student paper.

An effort is being made to increase attendance at the N. C. State Meeting from junior as well as senior students. Junior S.A.M.A. officers will be invited to the banquet as guests of the medical society as well as students.

The Presidents of S.A.M.A. Chapters report increasing interest among their members and each has worked hard and accomplished much to plan a most effective Sectional Program for the State Society Meeting.

It will be important to judge how well the section is received and to plan increasing its vitality.

William Peete, M. D., Chairman

COMMITTEE ON SCIENTIFIC AWARDS

The members of the Committee on Scientific Awards reporting have voted the following winners:

MOORE COUNTY AWARD:
Dr. Christopher C. Fordham, III, M. D.
"PROBLEMS IN THE DIAGNOSIS OF RENAL
PARENCHYMAL DISEASE"

WAKE COUNTY AWARD: Robert Stevenson Lackey, M. D. "SPECIAL PROCEDURES IN A COMMUNITY HOSPITAL"

GASTON COUNTY AWARD:
HAND REHABILITATION CENTER
Joseph W. Eades, M. D., and Hilliard Foster
Seigle, M. D., UNC Medical School, Chapel Hill

The committee earnestly requests the co-operation of each Section Chairman and asks that each of them see to it that the best paper in each section be chosen and forwarded to the Executive Director of the Society who will prepare copies of each paper for members of the Awards Committee.

L. A. Crowell, Jr., M.D., Chairman

CORNELL AUTO-CRASH INJURY SURVEY

Since the medical profession played such a vital role under supportive policy of the State Medical Society in the activity entitled above, it seems fitting that the record reflect the usefulness of the program through the years from September 1953 to its termination, actively April 1964, as reported as of June 1964, which date supercedes the latest annual meeting of the House of Delegates. Therefore, for the record, the following excerpt is presented with the suggestion to the Executive Council that this reference comment be accepted and as the conclusive point in this activity of the Society. The excerpt is as follows:

"Previous North Carolina-Cornell ACIR Studies North Carolina was the first state to undertake an ACIR program in cooperation with Cornell. A pilot study was initiated in Guilford County in September, 1953, in which all passenger cars in injury-producing accidents were studied. Following this initial experience the following studies were pursued:

- 1. Full Study -- November 1953 -- November 1955 A compilation of information of all personal injury and fatal accidents in five sampling areas comprising 3 or 4 counties at a time.
- 2. Full Study -- March 1956 -- March 1958 First random sampling plan. Combined full study (i.e., all passenger car injury-producing accidents) and property damage study.
- 3. Full Study and Recent Model Study -- February 1959 -- February 1961

Two year study conducted in four randomly selected areas. Full study conducted in two districts and recent model study in an entire troop area.

4. Full Study -- June 1961 -- June 1964

Study in administratively selected areas comprising two districts at a time. At the end of the first year the plan was modified to one district at a time and extended an ad itional year. This change in plan was occasioned by the special "Operation Impact" initiated at the Governor's request.

The pioneering and continued participation of North Carolina represents a most important contribution to the interstate ACIR program which:

- a. supplied the early findings which prompted the automotive industry to effect design modifications and innovations in passenger cars beginning with the 1956 models.
- b. supplied findings on the improved vehicles so that the calculated benefits of the specific modifications could be appraised, and
- c. added the non-injury accident data to more readily allow clinical comparison of the injury and non-injury accidents occurring under similar circumstances.

The Cornell Aeronautical Laboratory acknowledges the foresight and continued cooperation of the Department of Motor Vehicles under Commissioner Edward Scheidt and the State Board of Health under Dr. James W. R. Norton, State Health Director, in addition to the Medical Society of the State of North Carolina, James T. Barnes, Executive Director.

Respectfully submitted, James T. Barnes, Executive Director

REPORT OF THE A. M. A. DELEGATES

Report on actions of the House of Delegates

Miami Beach, Dec. 2 -- Health care for the aging, a new teletype communications system for the medical profession, a statement on human reporduction and recommendations from the Commission on the Cost of Medical Care were among the major subjects acted upon the House of Delegates at the American Medical Association's 19th Clinical Convention held November 29 - December 2 in Miami Beach, Florida.

Tribute was paid to the late Dr. Norman A. Welch, AMA Preisent who died on September 3, in a memorial statement from the Massachusetts medical society and in a resolution adopted by the House.

Dr. James Z. Appel of Lancaster, Pa., vice chairment of the AMA Board of Trustees and a member of the Board since 1957, was named President-Elect of the Association. He will become President in June, 1965, succeeding Dr. Donovan F. Ward of Dubuque, Iowa, who took office after the death of Dr. Welch.

To take Dr. Appel's place on the AMA Board of Trustees, the House elected Dr. Joseph B. Copeland of Austin, Texas, who for the past year has been serving as Deputy Commissioner of Health in the State of Texas.

Final registration at the convention reached a total of 9,356, including 4,118 physicians.

Health Care for the Aging

Definitive action on the issue of health care for the aging came with the House of Delegate's strong endorsement of Dr. Ward's Monday address, in which he declared that "We have no choice except to stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

Reaffirming the Association's opposition to the King-Anderson type of legislation, Dr. Ward said:

"If we have been right in the past -- and that is our unshakeable belief -- then we are right today. And we shall be righ: tomorrow."

Calling for renewed, intensive effort to prevent the passage of such legislation, he pointed out that "we do not, by profession, compromise in matters of life and death. Nor can we compromise with honor and duty."

Dr. Ward, expressing pride in the medical profession, concluded his address with these statements:

"I pray that we all gain strength for renewed effort by the simple reflection that what we are doing

is worthwhile -- that if the effort is great, the results of not making the effort would be unthinkable -- and, finally, what we are doing is vastly more important than ourselves.

"No more can be asked of us as citizens. No less should be offered by us in guarding our heritage of freedom."

To implement the ideas in Dr. Ward's address, the House gave unequivocal approval of a Board of Trustees suggestion that an expanded educational program be conducted in the next few months. In asking for this approval, the Board pointed out that "a variety of techniques and media must be utilized if the public, the Congress and special audiences are to be reached effectively."

The House took no action on three resolutions which would have altered the AMA position on health care legislation. Instead, the House adopted a resolution which urged "component associations to stimulate the state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care will be available."

The state medical societies also were urged to send representatives to two forthcoming conferences related to the issue of health for the aging -- one on December 13 to help plan the new educational program and the other on January 9-10, 1965, to consider further implementation and expansion of the Kerr-Mills programs.

Teletype Communications System

The House approved a recommendation from the Board of Trustees for establishment of a tele-type-writer communications service between the AMA and the state medical societies. The system will provide automatic and uninterrupted communications between AMA Headquarters and all participating state societies, and between the state societies without involving the facilities at the AMA Headquarters. The system also will enable any state society to communicate with all other TWX subscribers in the United States and Canada.

In approving the recommendation, the House emphasized that participation is optional with the state medical societies but it also urged each society to "seriously consider taking advantage of this rapid communications system." Installation and rental costs for the teletype equipment, both at AMA Head-quarters and at the headquarters of each participating medical society, will be paid by the AMA. The cost of transmitting messages will be paid by whichever organization originates each message. It is hoped that the new communications system will become operative no later than July, 1965.

Human Reproduction

Updating its policies on population control, "to conform to changes in society and medicine" and to "take a more positive position on this very important medical-socio-economic problem," the

House adopted the following four-point statement:

"1. An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

"2. The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total propulation and the individual family.

"3. In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"4. The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

In taking the action, the House also recommended that the AMA cooperate with the appropriate voluntary organizations in the field of human reproduction which have adequate medical direction.

Commission on the Cost of Medical Care

With modifications suggested by the Board of Trustees, the House approved 33 recommendations from the Commission on the Cost of Medical Care. The suggestions had been rearranged by the Board into four sections -- Research, Hospitals, Physicians and Miscellaneous. In accepting the Board report, the House also rejected a floor amendment which recommended that a medical advisory committee composed of practicing physicians be appointed to supervise the several studies which were suggested.

In presenting its conclusions and recommendations to the Board of Trustees, the Commission on the Cost of Medical Care expressed the hope "that the recommendations which are approved will help promote the wisest possible use of the medical care dollar and aid in the development of more meaningful data on the cost of medical care."

The House learned that a substantial number of the studies recommended by the Commission are already under way and that others are in the process of being implemented. The House also emphasized its appreciation of the importance of these continuing studies and urged that adequate funds be provided for maximum implementation of the recommendations.

Miscellaneous Actions

In considering a wide variety of annual reports, special and supplementary reports and resolutions, the House also:

Amended the Bylaws to permit the presidential inauguration to take place at a time other than Tuesday evening and approved a suggestion that the inaugural ceremony at the 1965 Annual Convention to be held on Sunday, June 20.

Amended the Bylaws to permit presentation of the AMA Distinguished Service Award at a time to be determined by the Board of Trustees and learned that the Board wishes to present this award at the scientific Awards Dinner;

Agreed that the AMA should cooperate with the U.S Public Health Service in eradicating the AEDES aegypti mosquito from the American hemisphere;

Urged strong support of the Woman's Auxiliary and asked the state and county medical societies to give serious consideration to the idea of joing husband-wife membership;

Agreed that a section on Space Medicine should not be created at this time;

Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, nondeductible contribution to independent political action committees on the society's annual dues billing stagement;

Approved a Board recommendation that the 1967 Clinical Convention be held in Houston, Texas;

Agreed with the Board that there should not be an increase in AMA dues at this time;

Reaffirmed its approval and support of the National Council for Accrediation of Nursing Homes and instructed the Board to re-evaluate the mission of the Commission on Medical Practice and take appropriate action.

The American Medical Association Education and Research Foundation reported to the House that one out of every six medical students, interns and residents in the U. S. is now receiving financial assistance from the Foundation's loan fund. The AMA-ERF also announced that Merck Sharp & Dohme Pharmaceutical company has made its fourth \$100,000 contribution to the loan fund and has pledged an additional \$100,000 in 1966.

Delegates are Badie Clark, M.D.; Millard Hill, M.D.; Amos N. Johnson, M.D.; Elias S. Faison, M.D., Sec.

COMMITTEE ON VENERAL DISEASE

The following is a summary of the V. D.'s Committee report for the year 1964-1965.

- 1. Routine blood tests as part of hospital admission: The Committee felt that one important source of case findings was being lost due to the fact that many hospitals had discontinued the routine use of a serological test for syphilis as part of general admission procedure. A letter was written to each hospital in the State and the majority of these answered that they have resumed routine serological testing as part of hospital admission or had never discontinued the practice. It is estimated that approximately ninety percent of our hospitals are now doing a routine STS on admission.
- 2. Promotion of V. D. teaching in our three medical schools. A sub-committee under the direction of Dr. William Fleming of Chapel Hill has been set up and is in the process of promoting increased teaching of venereal disease as a part of the four year medical school program at Duke, University of North Carolina, and Bowman Gray Medical School.
- 3. Epidemiological Assistance: The Committee endorses the program of the U.S. Public Health

Service and the State Department of Health in supplying epidemiological workers to assist the private physician in securing contacts of early syphilis. These workers are now available in all counties and will come to the physician's office and interview the patient if the doctor so wishes. The private physicians are encouraged to make use of this service.

The rates for early syphilis are as follows:

North Carolina		United States			
	1957	5 per 100,000			
	1962	13.7 per 100,000			
	1963	19.8 per 100,000	1963	11.9 per	100,000
	1964	20.6 per 100,000	1964	12.1 per	100,000

It is estimated that ten percent of syphilis treated by private physicians is being reported in the United States as a whole, and that thirty percent is being reported in the State of North Carolina.

Howard P. Steiger, M.D., Chairman

INSURANCE INDUSTRY LIAISON COMMITTEE

President Theodore S. Raiford; The Executive Council of the Medical Society of the State of North Carolina; Dr. David A. Welton, Chairman, Commission on Public Relations:

On behalf of the membership of the Insurance Industry Committee of this Society, it is my privilege to present this briefed review of the activities of this committee on behalf of the Society during the 1964-1965 year.

Meetings of the committee have been held quarterly, and at other times, at varied sites in the State and have been well attended. The committee meets jointly with the North Carolina State Committee of the Health Insurance Council. At several of the meetings, visitors and observers have been present by invitation. From time to time, special interest groups or representatives have been heard on matters pertinent to the promotion of the liaison activities between the insurance industry and the purveyors of medical care, especially the physicians of North Carolina.

Consideration and study were given to numerous areas of mutual interest applying to voluntary health insurance. For the purpose of this report, a few of the study areas discussed, researched, and, at times actively debated, are listed. Growing out of some of these areas, recommendations have been made to the Industry and to the Society.

1. Partially as a result of concern in this committee over the activities of certain insurance carriers with regard to company-instigated audits of patient records in certain hospitals, the committee supported a further liaison effort of an idustry sub-committee to set up a voluntary audit group that would be available on a non biased basis, rather than having individual company audits done in hospitals of the personal records of individual patients. This was to be done wherein there was question of irregularities in charges of hospitals and alleged "abuse of insurance" by certain hospitals. Such group was established by the industry representatives, the hospital association, and the hospital administrators.

- 2. Further support was given to the "Virginia-North Carolina 65 Plan."
- 3. A well-prepared presentation of a guest committee representing non surgeons, titled "Relationship of Non-Surgical Medical Care and Voluntary Pre-payment Health Insurance," was heard. The various means of broadening coverage in this health insurance area were studied at length. The consensus was that the chief difficulty in this area was in getting employee-employer groups to accept these broadened features of insurance coverage.
- 4. Utilization of medical care was a subject that was discussed at every meeting. As a final result, the committee recommended to the President and to the Council that a single committee be set up to study, recommend, and formulate standards in this area of utilization, and that such act for the Society in this connection.
- 5. Area planning as a means of conserving the health care collar came up for consideration and study. A project is still underway in connection with recommendations in this area.
- 6. Consideration was given to an attempt to secure and have adopted a workable report form for the reporting of "personal injury cases" to casualty insurance carriers and, at times, to plaintiffs attorneys. The committee expressed its dissatisfaction with the present report forms in use in that they did not follow standard history and physical format, and, therefore, required unnecessary physician time for their completion.
- 7. Among the other agenda items discussed were those in connection with life insurance examinations, case history requests relative to applications for insurance, confusion of language in insuring contracts, and misunderstanding of contracts by group insureds due to a lack of explanation.
- 8. Innumerable other facets of the liaison effort were also given proper consideration.

North Carolina Claim Review Service

The Claim Review Service function has reviewed a number of cases during the year. It is pointed out for emphasis that the Service acts only in the area of recommendations to the insurer as to his contractual obligation to his insured, based upon the policy language with reference to the matter of company allocation toward the payment of professional medical billings. At no time does the Service imply that it is setting, or attempting to set, any physician's fee.

Because of the enormous growth of major medical insurance in recent years, the C.R.S. realized the need for the adoption of certain definitions of terms commonly used in this type of contract. In order that the Society might be informed of at least three of these definitions, such is included in this report:

Where such definition is not specifically spelled out in the policy, then the following shall apply for the deliberations of the Claim Review Service relative to definitions of "usual", "customary", and "reasonable" fees:

a. Usual - The "usual" fee is that fee usually charged for a given service by an individual physician

- to his private patient (that is, his own usual fee)
- b. Customary A fee is "customary" when it is within the range of usual fees charged by physicians of similar training and experience for the same service within that same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)
- c. Reasonable A fee is "reasonable" when it meets the two foregoing criteria and in the view of the responsible Medical Society's review committee is justifiable considering the special circumstances of the particular case in question.

The Medical Section of the Claim Review Service, by a change in rules this year, now comprises all of the members of the Society's Insurance Industry Liaison Committee, thereby giving knowledgeable representation from all the geographical areas of the State and in all the subdivisions of medicine. Much research in the area of "going rates" has been done by members on a personal investigation basis. The committee is very aware of its responsibility to the profession and the public in this particular area.

The Service has declared that it is not in the public interest for a person or persons, other than the physician, to set a physician's fee in any given case.

The Service has declared that it is unwise for any insuring carrier to pay any indemnity to an insured wherein the physician performing the service is not identified in some fashion on the claim report form.

The Service finds itself in a position of declaring that the presence or absence of health insurance should not affect the consideration of the patient's ability to pay as set forth in the "Principles of Medical Ethics."

The Service has concerned itself with the question of utilization of so-called "prima donnas" of medicine by the well-insured. In this area, it prefers to handle consideration by applying the principles of "usual", "customary", and "reasonable".

The committee hopes that by means of this report one message will be carried to the membership of the Society, and that is that it is better for certain areas of disagreement between practitioners of medicine with reference to insurance and the third parties be handled by physicians as opposed to outside claim review bodies.

The committee further urges and again reminds the membership that the insurance side of the Claim Review Service will carefully review any areas of issue that might arise with reference to companies and their action. It is to be remembered, however, that loose philosophical statements or theories do not constitute an area for review. Such must be a case in point, and must be well documented, and supported by fact.

The committee anticipates an even more active service on behalf of its function in the ensuing years. If, by reason of an isolated opinion rendered, it happens to step on some individual's toes in any fashion, let it then be remembered that physicians are making these recommendations, and that each time a decision is made, the individuals involved in making the decision cannot help but recall and consider that they are themselves an individual part of the collective group of the profession; further, that they are aware there is borne a weight of responsibility, at times,

in connection with the public interest in matters of health insurance.

Today, we are in a rapidly changing pattern of socio-economics, and the things that each physician does can materially affect the future of medicine.

Frank W. Jones, M.D., Chairman

REPORT OF THE ACTIVITIES OF THE NORTH CAROLINA MEDICAL CARE COMMISSION FOR THE YEAR ENDED DECEMBER 31, 1964

Submitted by Physician Members of The North Caroline Medical Care Commission Representing the Medical Society of the State of North Carolina

Construction of Hospitals and Medical Facilities

Construction needs in the health field continue to accelerate. There presently is under contract or in planning some 35 projects with costs involving appromimately \$65 million. The utilization of hospitals continues to increase, requiring continuing enlargement and replacement. Upon completion of the projects now under contract or in planning for which funds have been encumbered, North Carolina will have 18,199 general and allied hospital beds representing approximately four beds per thousand. There are currently under construction or in the active planning stage approximately 1,700 new general hospital beds which will represent a net gain of 946 for the State. At the present time, there are also 272 long-term care beds under construction which will provide a net gain of 230 beds upon their completion.

A number of hospitals now are undertaking the development of long-term care units. There are also several large, freestanding nursing homes under construction using Hill-Burton funds.

The following statistics summarize the construction program since its inception in 1947:

General Hospitals	204 (10,208 beds)
T. B. Hospitals	2(100 beds)
Mental Hospitals	7(647 beds)
Chronic Disease Facilities	10 (629 beds)
Rehabilitation Facilities	13 (166 beds)
Outpatient Departments	17
Health Centers	88
Nurses' Residences	49 (2,999 beds)
Nursing Homes	9 (547 beds)

Congress in 1964 approved grants-in-aid for the construction of community mental health centers and facilities for the mentally retarded. The Medical Care Commission has been designated the agency to administer the construction program and a State Plan for the development of these facilities is being worked out cooperatively with the State Department of Mental Health.

Licensure of Hospitals

During the year 169 hospitals were licensed repre-

senting approximately 19,000 beds. Hospitals licensed by medical type are as follows:

General	144
Mental	0
Tuberculosis	4
Rehabilitation	4
Maternity	0
Pediatric	1
Eye, Ear, Nose, Throat	2
Physician's Clinic	10
Chronic Disease	4

Student Loan and Scholarship Programs

The table on the following page summarizes the student loan and scholarship programs to December 1, 1964.

Seventy-three per cent of recipients completing their training are either presently practicing or have completed the required number of years of practict.

- B. The following is a summary of a survey just completed involving only the 40 physicians trained under the rural loan program who have practiced the required number of years in a rural community.
- l. Number remaining in same rural community upon completion of practice obligation 26 (65%)
- 2. Number remaining in North Carolina but in an area not defined as a rural community by Rural Loan Statutes 7 (17.5%)
- 3. Total number remaining in North Carolina 33 (82.5%)
- 4. Number practicing outside the
 State of North Carolina 6 (15%)
 5. Present address unknown 1 (2.5%)
- C. Loans and scholarships totaling \$1,290,000 have been awarded since 1945. Almost \$66,000 in notes have been cancelled by service under the mental health facilities and nursing instructors' programs and \$458,000 have been repaid in loans with collections averaging \$8,747.26 per month this year. Notes outstanding total \$766,000. There is an unencumbered balance of approximately \$416,000 to support new students.

The following footnotes refer to items in the loan and scholarship table on the following page:

- I/ Reasons given by recipients: Their specialties not needed in rural communities (urology, cardiology, radiology); family difficulties; marriage; pregnancy; practice in areas exceeding population limitation; voluntary military enlistment; moved to another State; health; failed to pass State Boards; one became a foreign missionary.
- 2/ Number defaults divided by number students minus number in school,

Respectfully submitted, J. Street Brewer, M.D. Powell G. Fox, M.D. Harry L. Johnson, M.D.

A SUMMARY OF THE LOAN AND SCHOLARSHIP PROGRAMS By: Mrs. Janet Proctor, Administrative Assistant

Α.			1	1				1	
1945-December 1, 1964	Rural Loan	Basic Nursing	Special- ized Nursing	State Mental Facilities	Nurse Inst.	Nurse Anex.	Med TECH.	Total	%
Total NO. Students Approved	231	47		78	19	16	5	396	100.0
In Practice	30	4		11	5	3		53	13.4
Completed Practice Obligation	66	2		21	3			92	23
Enrolled in School	46	16		16	7	12	5	102	26
Postgraduate Training or Military Obligation	36			8	1			45	11.4
Defaults: 1/ Graduates	26	11		14	2			53	13.4
Academic Failures	16	7						23	6_
Withdrawal from Sch.	10	7		8	1	1		28	7
2/ Percentage of Defaults	28.6	80.6		25.0	25.0	25.0	2 5.0	35.4	

REPORT FROM HOSPITAL CARE ASSOCIATION

We are pleased to report that 1964 was another year of outstanding progress for the Hospital Care Association. In both its Blue Cross Plan for hospital service and its Blue Shield plan for medical service, the Association registered substantial gains in new enrollment and benefit payments for the year.

For its combined Blue Cross and Blue Shield operations, the Association had a net gain of 21,638 new members. The increase in enrollment raised total membership to approximately 485,000 at year's end. Benefot payments exceeded \$16,650,000, a gain of more than \$2.3 million over 1963 payments. Nineteen sixty-four marked the 31st consecutive year that Hospital Care Association has shown an increase in erollment and benefit payments. The oldest hospital and medical service plan in the state, it has grown each year since it was established in 1933.

The Association suffered a great loss on June 9 when B. R. Roberts, president since 1935, passed away following ax extended illness. A Resolution of Appreciation for the services performed by Mr. Roberts during his long tenure as president was adopted by the Board of Directors.

Mr. E. M. Herndon, executive vice president of Hospital Care Association since 1939, was elected by the Board to succeed Mr. Roberts as president. The office of executive vice president was abolished.

Mr. A. S. Brower, finance officer for Duke University and a longtime Director of Hospital Care Association, was elected Chairman of the Board. Dr. J. Street Brewer and Mr. J. P. Richardson were elected vice chairmen.

BENEFITS

At the end of 1964, Hospital Care benefit payments averaged approximately \$1,400,000 per month--\$320,000 per week, or \$65,000 per working day.

Rising hospital costs, enrollment growth, and increased utilization are responsible for the Association's ever-increasing benefit payments. As hospital charges continue upward, Blue Cross benefits are being increased to meet them.

The staff of the benefits department was enlarged during the year to meet the increased demands for service and to assure prompt handling of claims.

During October, workshops designed to facilitate the prompt and efficient processing of claims were conducted by the benefits department in Asheville, Charlotte, Greensboro, Raleigh, Greenville, and Fayetteville for hospital personnel from all over the state. Similar conferences for physicians' secretaries are planned for 1965.

ENROLLMENT

The Hospital Care annual enrollment gain of 5 percent was double the Blue Cross national average of 2 1/2 percent. The gain was about evently divided between group and nongroup enrollment. In group enrollment, some 235 new employee-groups were established. Hundreds of old groups increased their basic coverage and added Extended Benefits. Rate increases required much of the representatives' time during the year.

In nongroup enrollment, another "Easy-Joining Days" open enrollment was conducted in March. Approximately 7,000 new members were enrolled during this special campaign. Rural enrollment through Farm Bureau groups was expanded to include eight addi

tional counties in western North Carolina. Now serving Farm Bureau groups in 63 counties, the Hospital Care rural enrollment program covered 61,147 members at the end of 1964, a 6.9 percent increase over the previous year.

Upgrading of benefits on both existing contracts and new sales continued in the group and nongroup departments. Room allowances and surgical schedules were increased on approximately 25,000 contracts. Endorsements covering in-hospital medical care, cancer and dread disease, and outpatient care in physicians' offices were added to many old and new subscribers' certificates. Sale of a special Student certificate for college and trade school students was promoted in the fall.

BLUE SHIELD DEVELOPMENTS

Efforts toward converting existing memberships to the Doctors Program of the Medical Society of the State of North Carolina continued. The number of members enrolled on Doctors Program contracts increased by 39,528 during the year.

Blue Shield Participating Physician agreements were signed by 89 additional physicians, bringing the total number of such agreements in force to 2,281, or 76.03 percent of the state's physicians in active practice.

The Hospital and Physicians Relations Department, established in 1963, was expanded to meet the increasing demands of Blue Cross and Blue Shield programs. Two full-time representatives, Robert M. Ward and W. A. Weed, were assigned to the department to inaugurate a regular program of visiting hospitals and physicians to discuss Blue Cross and Blue Shield problems and procedures, including education of claims personnel and general audits of records relative to claims.

The Blue Shield Newsletter, designed to keep HCA Participating Physicians and their office assistants informed about significant new Blue Shield developments, was published bimonthly. The Newsletter was disseminated to all physicians.

administration and planning

Programing for the IBM 1401 data processing equipment continued. Procedures assigned to the computer during the year included introduction of group billing on a parallel basis, all payments to physicians and hospitals, and preparation of the Forms 1099 (information returns) for the Internal Revenue Service. This modern equipment will make it more economical for the Association to handle expanding work schedules as enrollment and claims volume increase. public relations and advertising

A comprehensive, year-round educational and advertising program was directed to the Association's several primary publics, i. e., enrolled groups; nongroup subscribers; member hospitals; participating physicians; group prospects, civic clubs and other community groups; our own employees and their families; and the general public. Both mass media and personalized newsletter mailings were employed.

In advertising, we continued sponsorship of "Profile," a 15-minute weekly program on the state's two largest radio stations. The "Medicine of the

60s" series of hour-long medical documentary films, which the Association has sponsored over the past three years, was completed. This series was replaced by a new series of locally-produced documentary films on major programs and issues in the health care field in North Carolina. The first of these health specials, "Health Care for the Aged" and "Pressure to Save--The Hyperbaric Oxygenation Chamber at Duke University," were shown in prime time on five North Carolina TV Stations. The series will continue in 1965 with explorations of the rising costs of hospital care and other subjects.

Our Public Relations Department worked closely with the Durham-Orange County Medical Society in staging the first North Carolina Health Fair at Duke University in April. A film of the Health Fair was presented by the Association to the Medical Society for the use of other county societies interested in sponsoring a Health Fair. The Hospital Care exhibit at the Health Fair, which depicted the reasons for the rising costs of health care, has since been shown in hospitals throughout the state. It is now booked ahead at three-week intervals through the summer of 1966.

Newspaper and magazine advertising and publicity was carried out year-round in daily and weekly papers and state magazines.

Staff personnel made many talks to civic clubs and other groups on rising hospital and medical costs. A brochure on this subject, produced and disseminated to the public through hospitals and doctors' offices, was commended by The Joint Council for the Health Care of Chronically III and Aging. The Public Relations Director served a second term as Chairman of the North Carolina Committee on Nursing and Patient Care, a state-wide group representing the major health disciplines and the public, dedicated to general improvement of patient care. Several important projects were initiated by the Committee during the year.

financial condition

The financial condition of the Association remained sound. As of December 31, 1964, assets were \$10,500,043, with liabilities of \$4,933,398 and a reserve of \$5,566,645. The reserve fund is equal to 3.67 months of average operating expense, which is sufficient to meet the requirements of the national Blue Cross and Blue Shield approval programs and the North Carolina Department of Insurance.

NONGROUP RATE INCREASE

Due to steadily rising hospital costs, the Association was forced to apply in October to the North Carolina Commissioner of Insurance for permission to raise rates on all its nongroup certificates. On December 18, after a public hearing as required by law, and a thorough examination of the application, Insurance Commissioner Edwin S. Lanier granted the increase, which averaged 24.5 percent, to become effective January 1. The Association had been losing money on its nongroup business for some time. The rate increase is expected to put the nongroup department on a self-supporting basis in 1965.

UTILIZATION PROGRAM

In an effort to minimize the increases of Blue Cross and Blue Shield dues in the future, Hospital Care developed a new program to control unnecessary usage of benefits. The program, which began in the late fall, calls for a concerted effort on the part of physicians, hospitals, government, health agencies, the public, and Blue Cross and Blue Shield Plans to do everything possible to stabilize Blue Cross and Blue Shield dues by controlling unnecessary utilization.

The program as adopted provides for the establishment of three major divisions: (1) an adequate organization of personnel and equipment to do the job, (2) the gathering of sufficient statistical data so that the causes and extent of over-utilization may be determined; and (3) the implementation of a continuing program to work toward the control of unnecessary utilization through education, audits, and other means.

Althrough it is too early to forecast with any assurance of accuracy the results of this program, the potential saving to Hospital Care and its subscribers is enormous. The most immediate benefit to be derived from such a program is to give the Association the ability to demonstrate that it has a positive program aimed at controlling costs and utilization. This assurance will help to hold groups that might otherwise be lost. It will also aid in new enrollment as employers become more sophisticated in selecting an insurance carrier.

Should the Association be able to effect a reduction of even half a day in the average length of stay, as a result of such a program, the overall estimated saving for 1965 would exceed \$1 million. If the admission rate to the hospital could be reduced from 153 per 1,000 members to 150 per 1,000 members—a reduction of only three cases per thousand members—the annual saving would amount to more than a quarter of a million dollars.

The physician is the key man in any utilization program, since only he can admit or discharge a patient from a hospital. As your duly elected representatives to the Hospital Care Board of Directors, we urge the careful attention of all members of the Medical Society of the State of North Carolina to this important new program. With your help, much can be accomplished; without your help, little will come of it.

The confidence, cooperation, and encouragement of its participating physicians contributed importantly to the progress Hospital Care Association made in 1964. The Association expresses its gratitude for this continuing support.

J. Street Brewer, M.D., Chairman

REPORT FROM HOSPITAL SAVINGS ASSOCIATION

The 29th year of Hospital Saving Association's operation was marked by continued growth -- a net gain of 27,766 members so that 723,160 North Carolinians had Blue Cross and Blue Shield protection at the end of 1964.

Total benefit payments also increased to a total of twenty-eight and a half million dollars. This was accounted for by growth; upgrading of benefits to add benefits for inpatient medical care (313,948 members up from 260,636 at end of 1963), higher surgical schedules, adding "Extended Benefits", etc.; and by continued increase in hospital costs. Ancillary hospital charges increased by 10.7%. The North Carolina Insurance Department, in December 1964, and after much study, granted a rate increase for non-group subscribers which will improve the 1965 experience for this segment of business.

The Association virtually completed transfer of record keeping to a computer basis and is therefore better able to secure refined statistical data much quicker than in the past. Information concerning utilization of benefits in a particular area or for a particular illness or condition is available for review by concerned County Societies or Hospital Staffs.

We were most gratified by the interest and concern shown by President, Dr. T. S. Raiford, in the matter of proper utilization of medical facilities and prepayment resources and the possibility he raises of long range joint consideration by all the organizations and professions affected.

The Blue Shield Committee of the Medical Society under the experienced leadership of Dr. W. Z. Bradford, has provided capable guidance to the Association with regard to benefits for professional services, particularly as related to newly developed procedures and operative techniques. We are grateful for fine work of this Committee and anticipate that the increasing complexity of medical practice and prepayment will make the Committee's guidance increasingly important to the Association.

As in the past years, the Association is appreciative of the efficient administrative cooperation of the Headquarters Office of the Medical Society and the assistance of Mr. James T. Barnes.

A financial report for the year is to be found on the following page.

E. McG. Hedgepeth, M. D.

\$26,104.55

REPORT TO THE HOUSE OF DELEGATES MEDICAL SOCIETY STATE OF NORTH CAROLINA FROM

HOSPITAL SAVINGS ASSOCIATION, INC. CHAPEL HILL, NORTH CAROLINA

,,,,,	1963	1964
Total Assets	\$13,461,884	
Legal and Operating Reserve		
Total Fee Income (Regular	5 1,004,010	1,412,010
, ,	00 455 056	80 040 000
Subscribers)	22,457,976	26,248,666
Total Claim Payments	00 000 000	04.0== 0==
(Regular Subscribers)	20,367,378	24,257, 075
Operating Expenses - % of		
Fee Income	8.15%	7.80%
Total Claims Paid - All Pro-	-	
grams Administered by		
HSA (Includes Medicare		
FEP)	\$24,567,237	\$28,459,811
Blue Shield Participants	693,702	* 721,907*
Blue Shield Claims Paid	,	•
Number	161,242	187,200
Amount	\$ 4,860,423	\$ 5,843,296
Blue Cross Participants	698,394*	
Number Inpatient Admiss		•
Amount Paid Inpatient	,	,
Cases	\$15,669,969	\$18,722,575
Days Paid		748,039
Average Stay		6 6.80
Average Payment Per Ca	se \$ 151.26	\$ 170.29
Admissions Per 1,000 Per	- 0	Ψ 21.0 . 20
Year	152	152
National Blue Cross Per	102	102
1,000 Per Year	145	148
1,000 Fel leal	140	140

^{*}Includes Subscriber Participants in Administered Accounts Numbering 75,125 76,206

AUDITORS' REPORT (Continued from Page	13)
SCHEDULE 2 (Continued)	
Pro Rata Portion of Two Gingher Valets - #7-6-U 8.83	
TOTAL RURAL HEALTH AND MEDICAL CARE COMMITTEE	624.70
ANNUAL SESSIONS CONVENTION: Portable Lectern \$ 29.67 Stenorette Machine #219618 205.06 Stenorette Machine #214740 \$ 196.75 Stenorette Machine #216837 196.75	
TOTAL ANNUAL SESSIONS CONVENTION \$	628.23
INTRA-FUNCTIONAL ACTIVITIES: Gray Secretary's Desk \$224.35 Gray Secretary's Chair 36.77	
TOTAL INTRA-FUNCTIONAL ACTIVITIES	261.12
TOTAL OFFICE FURNITURE AND FIXTURES \$	31,320.26
REAL ESTATE: Land - Durham-Raleigh Highway - (Schedule - 3) OTHER ASSETS.	26,104.55
Capital Stock - State Medical Journal Advertising Bureau, Inc.	200.00
TOTAL CAPITAL ASSETS - TO EXHIBIT "A" \$	57,624.81
SCHEDULE 3 SCHEDULE OF BUILDING SITE COSTS	
Options 12 Months Ended December 31, 1963	450.00
Land Purchase - Durham-Raleigh Highway Legal Service Survey and Map of Property Architect Service	24,650.00 126.75
TOTAL - TO SCHEDULE - 2 \$	26,104.55

TOTAL - TO SCHEDULE - 2



REPORT OF THE EXECUTIVE COUNCIL

REPORT OF THE SALIENT ACTIONS OF THE EXECUTIVE COUNCIL MEETINGS OF SEPT. 27, 1964 AND FEBRUARY 7, 1965



REPORT OF THE EXECUTIVE COUNCIL

REPORT OF THE SALIENT ACTIONS OF THE EXECUTIVE COUNCIL MEETINGS OF SEPT. 27, 1964 AND FEBRUARY 7, 1965

THE EXECUTIVE COUNCIL MEETING SEPT. 27, 1964

The 1964 Fall Meeting of the Executive Council of the Medical Society of the State of North Carolina, held at the Mid-Pines Club, Southern Pines, North Carolina, convened in the Meeting House at 9:10 o'clock A.M., September 27, 1964, President T. S. Raiford presiding and Dr. J. S. Rhodes rendered the invocation. Secretary Chas. W. Styron called the roll and declared a quorum present.

Upon motion made, seconded and voted the reading of the previous minutes were disposed of without reading.

The Committee on Finance report, including the 1965 budget, was presented, explained and recommended to the Council by President Rhodes due to the illness and absence of Dr. Wayne Benton, the report having been developed by the Committee on Finance under the chairmanship, pro tem, of Dr. Elias C. Faison. The budget reflected an anticipated income of \$253,345 and expenditures authorized in the aggregate of \$253,265, or a balance of \$80. Anent this small cushion the Committee recommended the implementation of a \$70.00 membership dues for 1965 as authorized by the House of Delegates in 1963. The budget estimate included a new item of \$600 for Commissioner expense; SAMA Chapter member subscription (in part) to the N. C. Medical Journal; On motion made, seconded and voted the report was accepted, including the detailed budget for 1965 here to attached and made a part of the report of the Committee on Finance.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

BUDGET ESTIMATES

January 1, 1965 to December 31, 1965

RECEIPTS: (ESTIMATED)	\$284,345
Estimated balance January 1, 1965	Nil
Assessment	
3100 paying members*	219,800
Sales (estimated on 1964)	1,500
Author Contributions to Cuts	250
Revenue Unexpected (estimated)	400
Technical Exhibits (estimated)	21,000
Journal Net Advertisement	
(estimated Local on 1964)	8,000
Journal Net Advertisement	
(estimated National on 1964)	25,000
**AMA Remittance 1% of dues	
processed (estimated on 1964)	1,395
Annual Banquet Revenue	
(700 @ \$10 each)	7,000

EXPENDITURES: (ES'	ΓΙΜΑΤΕD) 255,263
Schedule A	102,861
Schedule B	61,956
Schedule C	23,601
Schedule D	5,018
Schedule E	14,000
Schedule F	31,162
Schedule G	16,667
EXCESS OF RECEIPTS	5
OVER EXPENDITUR	ES 29,080
EXCESS OF EXPENDIT	TURES
OVER RECEIPTS	
RESERVES: (Costs, \$26,	104.55 - Land)
\$143,528.34/11,797.496	
SUBMITTED TO COMM	HITTEE ON FINANCE
Sept. 3, 1964	
SUBMITTED TO EXEC	UTIVE COUNCIL FOR
APPROVAL Sept. 27,	
SUMBITTED TO HOUS	E OF DELEGATES FOR
APPROVAL	, 19
*Based on dues @ \$70]	per member per annum
**To be appropriated to	Secretarial Budget A-6

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA 1965 ESTIMATED BUDGET ACCOUNTS

١.	EXI	ECUTIVE BUDGET		\$102,861
	A-1	President, expense of (travel		
		and communications)	6,000	
	A-3	Secretary, travel of	1,000	
	A-4	Executive Director-Treasurer	•	
		salary of	18,000	
	A-5	Executive Director-Treasurer		
		travel of*	5,000	
	A-6	Executive Office, Secretarial		
		and Clerical Assistants**	32,000	
	A-7	Executive Office, equipment		
		for and/or replacements	3,000	
	A-8	Executive Office, expense of		
		(12 months rent, communi-		
		cations, printing, and		
		supplies, repairs and repla		
		ments of expendables)		
		Bonding (in effect to 1966)		
I	1-10	Audit (Quarterly & Annual)		
1	A-11	Taxes (salary tax)	1,685	
Ė	1-12	Insurance fire, compensation		
		and employer's liability	293	
A	1-13	Membership Record System		
		(addition to)	100	
F	1-14	Publications, reports and		
		executive aids	200	
1	A-15	Insurable: interest insurance		
		and retirement plans	1,371	

A-16	Assistant Executive Secretary		C-11	Committees in general,		
22 20	of Public Relations,			expense of	2,500	
		,100	C-13	Committee on	,	
Δ 17	Rural Health Consultant,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Occupational Health	200	
W-T1		5,772	C-16	Committee on Negotiations	250	
A 10	Assistant Executive Secretary,	,,,,,		Committee on Student AMA		
A-18		,400	0-11	(Section & Transportatio		
		,,400		& Delegate to SAMA on		
A-19	Rural Health Consultant,	000			е	
		2,000		each Medical School	1.40	10
*Basi	s: Real for personal maintenanc	e and travel		Chapter (3)	1,42	ь
@ 7	c per mile and/or common carr	rier rate and	C-18	Committee on Disaster		
	official purposes.			Medical Care	50	0
**Any	revenue derived from collection ef	fforts related	C-19	Committee on Industrial		
to A	merican Medical Association du	ies and pro-		Commission	100	
cessi	ng of same shall accrue to this	item of the	C-20	Committee on Constitution		
Budg				and By-Laws	Nil	
			C-21	Committee on Medical Legal	100	
B. JOU	JRNAL BUDGET	61,956	C-22	Committee Advisory to N.	C.	
B-1	Journal, publication 38	,000		Highway Patrol on Traf		
	Journal, cuts for	500		Safety	100	
B-3	Editor, salary of 2	,310	C-23	Committee on Venereal Disea		
		,680		Committee on Anesthesia St		
	Editorial Office, expense of	,	0-24	Committee	400	
D-0	(12 months rent, communi-		0.00	Committee on Blue Shield	250	
	cations, printing and supplies		C-26	Committee on Blue Snield	230	
		450	C. INT	RA-FUNCTIONAL ACTIVI	TY	
D 4	repairs and replacements)	490		BUDGET		
B-6	Journal Business Manager's				400	
	Office, expense of (12			Committee on School Health	400	
	months communications, prin	it-	C-28	Committee Advisory to N. C.		
	ing and supplies, repairs			Board of Public Welfare	100	
	and replacements)	450	C-30	Committee on Liaison to		
B-7	Business Manager's Office,			Insurance Industry	500	
	equipment for	100	C-31	Rural Health Function (st	a-	
B-8	Journal, travel for			tionary) \$200; Sponsorsh	ip	
	(Local and National)	200		of 4-H Health activity f	or	
B-9	Taxes (salary tax)	266		one trip to National 4-H		
	Sales tax on Journal sub-			Club for State Health Win		
	scriptions and Roster sales	500		\$500; & Dues Rural Heal		
B-11		,500		Safety Council, \$100	800	
	Executive Council Reports,	,	C 20	Committee on Relative Value		
D-12	Transactions, Annual Reports	C C	C-52	Schedule	100	
		.000	C 00	DOMO THE PARTY	100	
	printing of	,000	C-33	Committee Liaison to N. C.	050	
C. INT	RA-FUNCTIONAL ACTIVITY			Pharmacy Association	250	
	BUDGET	23,601	D EX	TRA FUNCTIONAL ACTIV	ITIES	
C 1	Executive Council, espense of		D. Lin	BUDGET		5,01
C-1	and travel of Councilors		5.4			-,
		500	D-1	Delegates to AMA, expense		
		,500		of (4 to each annual and		
C-3	Legislative Committee, expense			Clinical Session	2,018	
	of (Local and National			Conference dues	200	
		,000	D-3	Woman's Auxiliary (contribu		
C-4	Maternal Health Committee,			tion to entertainment, tra-		
	expense of (secretarial, Con	1-		to National Auxiliary for	r 2	
	munications, printing and			and productions; History		
	supplies) 3	,600		factory-\$300.00)	2,800	
C-7	Scientific Exhibits Committee					4.4.00
- •	and Audio-Visual Program,			BLIC RELATIONS BUDGE'		14,00
	expense of	675	E-3	Committee Chairman, out of		
C-8	*	500		State travel	500	
	Committee on Grievances	200	E-5	Public Relations Equipment		
	Committee on Chronic Illness 2,			for,	1,250	
0-10	Committee on Cittoria annous =					

16,667

MedPac for use as an educational fund. After

being seconded, it was discussed at length. A sub-

stitute motion, duly seconded, directed that the

authorization be deferred to the next meeting of

E-6	Public Relations Office, expense		F-11 Badges (members, guests, exhi	bi-
	of (12 months rent, communi-		tors, auxiliary)	150
	cations, printing and supplies,		F-12 Reporting Service for Transact	ions
	repairs and replacements) 5,000		4	,400
E-8	Publications and		F-13 Rental, extra facilities, trucks	,
	Executive Aids 100		for sections and/or exhibits	250
E-9	Audio-Visual depiction; pho-		F-14 Exhibitors entertainment (at 2)	
	tography, radio-motion picture,			,000
	production, distribution and		F-15 Banquet expense and places	,000
	printing, purchase of			F00
	films, etc. 300			,500
E-10	Educational distribution; reprints,		F-16 Police Security	312
11-10			G. MISCELLANEOUS BUDGET	16,667
	periodicals, press materials,		or resolution by board	10,001
	pamphlets and dodgers for		G-1 Legal Counsel, retainer	
	educational purposes; produc-		fees for 7	,000
	tion, distribution and printing,		G-2 Reporting (Executive Council,	
	binding, stuffing and		etc.)	,700
	mailing 800		G-3 Fifty Year Club pins and	,
E-11	News and press releases,		certificates, and President's	
	production and printing of 400		Jewel	185
E-12	Public Relations Bulletin,			,500
	production and printing of 2,700		G-5 Retirement system for Society	,000
E-13	State High School Science Fair			999
	Program, expense of 200		G-6 Advarolem Taxes	,282
E-14	Exhibits and Displays: Pur-			325
	chase, rental, production,		G-7 Association of	0.50
	fabrication and		Professions Loan	350
	transportation of 650		G-8 N. C. Hospital Association	
E-15	Annual Officers Conference 1,000		Recruitment Program	
	Physicians Press Award Nil		Health Careers	500
	Public and personified activities		G-9 AAMC (Association of Ameri-	
	in the field of Public		can Medical Colleges)	225
	Relations 600		G-10 Commissioners, expense of	600
T 10	Collateral Public Relations			
E-10	with other committee		The Executive Council moved into ex-	xecutive ses-
			sion.	
	activities 500		Consideration was given to a retirem	ent plan for
F. AN	NUAL SESSIONS (111th)		the Executive Director by an eight year	
	CONVENTION BUDGET 3	1,162	funding for an estimated \$520 per mo	
F-1	Programs, Production of 1,750	•	under a contract for a minimum of ter	
	Hotel and Auditorium		death benefits based on the accrued ca	
12			the contract and at an overall cost of \$2	
F-3	expense 5,200 Publicity promotion, expense		Society paid from the reserves. A	
r -9				
17.4	of (reporters and expense) 700		made and seconded that such a plan a	_
r-4	Entertainment (general		ture be approved. Upon the question	
77.5	involving personnel) 900		the motion carried. (Let it be stated the	
F'-5	Orchestra and floor		fered plan and finance were determin	
	entertainment 2,500		weeks to be inadequate and this plan	was not put
F-6	Guest Speakers (5) expense		into effect.)	
	of and/or honorarium for 1,000		The Executive Council adjourned th	
F-7	Banquet Speaker,		session and immediately assumed the re	egular meet-
	fee and expense 550		ing.	
F-8	Electric Amplification, opera-		Recognitions of Hon. Willis Smith,	
	tors, installations and		Commissioners and the new Councilors	s was made
	screening auditorium 250		by the Chairman, President Raiford.	
F-9	Booth installations, supplies,		A motion to approve the recommends	ation of the
	expense, signs, (Scientific		Finance Committee for an allocation of	

and Technical) including ex-

F-10 Projection, expense of

(service rentals)

hibit expense & promotion 6,000

700

the Executive Council on February 7, 1965. The motion carried.

On motion made, duly seconded, and by vote carried, the report of the Committee on Legislation as to National Legislation was approved as related to the status of Medicare in Congress; the position of the N. C. Congressmen in opposing Medicare; provision for NLN accreditation under the Federal Nurse Education Act of 1964 with recommendation of petition to the U. S. Commissioner of Education not to approve NLN accreditation as a criteria for allocating funds to N. C. Hospital Schools of Nursing.

The Committee on Legislation further reported on activities related to implementation of the Kerr-Mills Law (MAA) in North Carolina in reference to Department of Welfare in employing Dr. Cynthia Hardison as Medical Director; the initiation of out-patient hospital services in diagnostic x-ray and laboratory services and the vendor payment of such benefits; related to a proposed bill of the N. C. Psychology Association unfavored by the Medical Society due to medical therapy implications; related to possible enactment of changes in the Sterilization Law permitting male vasectomy as an office procedure; related to medical concern in the reporting methods contained in a proposed law on the Battered Child Syndrome; related to a proposed bill to amend the N. C. Nurse Practice Act containing unfavored mandatory factors, an unfavored specific method of Nurse Board appointments which the Society will oppose, and favored modification to authorized associate degree education of nurses in the secondary colleges of the State; related a general proposal for a twoyear School of Medicine at East Carolina College with the recommendation that the President be authorized to appoint an ad hoc Study Committee on new medical school proposals; related to sponsorship of registrations at U.S. Chamber of Commerce Annual Public Affairs Conference in February 1965; related to information that the Durham-Orange Component Society favors compulsory tetanus toxoid requisite to state drivers license, and related to educational efforts in cooperation with the investor-owned utilities on government control of public services. Motion to accept the report was made, duly seconded, and upon vote carried.

Mrs. Amos N. Johnson, President of the Auxiliary of the Medical Society, was recognized and presented a report of extensive ectivities of the Auxiliary for the year.

On motion, duly seconded and on vote carried, the Treasurer was authorized to contribute the sum of \$100 to the National Society for Medical Research.

On motion, duly seconded and on vote carried, to approve an amended draft of the By-Laws in describing the functions of the Committee on Blue Shield with the recommendation the amendment be presented to the House of Delegates for action in

The report of Dr. W. Howard Wilson, Commissioner on the Advisory and Study Commission, relative to AMERF activities and the need for education and understanding among member contributing physicians and the need for clarification of channels of contributing for North Carolina Alumni was suggested; relative to the Committee on Medicare to Dependents of members of the Armed Forces and the favorable status of the present contract was reported as not indicating changes at negotiation in 1964; relative to the inclusion of Junior Class officers of State Chapters of SAMA to participate in SAMA annual section and social functions at the State Society Annual Meeting was recommended; relative to the consideration of the Society Relative Value Schedule by the Committee on Relative Value Scale looking toward the development of a tentative recommendation to supplant the present Relative Value Schedule with the 1964 California Relative Value Schedule after a review as to possible gross inequities and committee obpections and some plan to be developed for wider knowledge on the Relative Value Schedule; relative to activities of the Committee on Marriage Counseling anent a guest program participant and breakfast conference at the Annual Sessions and a symposium on marital counseling factors in the Spring of 1965. On motion, duly seconded, that the report be accepted, carried by vote.

On motion, seconded and on vote carried, the SAMA Committee was instructed to make recommendations to the Finance Committee for Executive Council approval as to the specific number of junior members to be invited to the Annual Session SAMA Section Meeting.

President Raiford cited changes in the structure of the Committee on Arrangements which is identified under the Annual Convention Commission and recognized Dr. Paul Maness as Commissioner to report for the several committees thereunder relative to the Committee on Scientific Works outlining the format for 1965 Meeting in Charlotte, including eminent out-of-state speakers to be invited and a panel of in-state deans on medical education in the three schools of medicine; relative to the format of the Committee on Audio-Visual Postgraduate Instruction morning and afternoon schedule of presentations at the Annual Sessions; relative to the extensive format for exhibits under the Committee on Scientific Exhibits and; the lack of reports from the Committees on Scientific Awards and Credentials; relative to a Craise proposal unfavorably considered by the Committee on Arrangements after extensive hearings on proposals and the detailed arrangements for the full utilization of the Charlotte Merchandise Mart; the revised policy by which the exhibitors party is to be integrated with the social functions of the Mecklenburg County Medical Society into a major social hour for Monday evening of the Annual Sessions; staging of the President's Banquet at the Park Center in Charlotte with music by the Jan Garber Orchestra, and; the assignment of Queen Charlotte and Barringer Hotels as headquarters for the Society and the Auxiliary, respectively. On motion, duly seconded and by vote carried, the report was approved.

Motion was made that the 1967 Annual Sessions be held in Asheville. The motion was duly seconded and on vote carried.

President Raiford recognized Dr. Mark Lindsey as Commissioner for the Professional Service Commission and report: relative to Committee on Disaster Medical Care and a recommendation that each component county society have at least one meeting devoted to disaster medical care, recommendation that the N. C. Highway Commission be requested to implement markers on the highways and maps as to the location of each hospital throughout the State. On motion, duly seconded and carried, these recommendations were approved.

Commissioner Lindsey further reported on the activities of the Committee on Eye Care as to medical report for driver's license information with the opinion that the entire visual portion be removed with the exception of that which reads "without glasses" or reads "with glasses" and no entry of type equipment used in test plus an addendum "Are you now receiving benefits from any blind agency or do you receive double income tax deduction for blindness?" ;related to activities of the Committee on Professional Insurances in which use-premium ratio will be reevaluated January 1965 based on a full year under the four physician classifications instituted in 1963 and recommendation that every case involving liability claim under the plan be brought before the Committee for review and recommendation, as well as all renewals involving questions of insurability be brought to the Committee for review; related to the Committee on Necrology in recommending the Memorial Service format be not changed in 1965; relating to the Committee on Nursing opposing the draft of a bill to revise the Nurse Practice Act for North Carolina, opposing some factors contained in the 1965 Roy Brown report on a survey, with recommendations, for the N. C. Board of Higher Education and opposing some factors of the Guidelines on Nurse Education standards promulgated by a state-wide Committee of Nurses representative of the Nursing Association and the N. C. League of Nursing; relative to the Medical Society supporting legislative authority and appropriation for financing diploma schools of nurse training, and; related to a recommendation of petition to U.S. Commissioner of Education of HEW opposing the recognition of the National League of Nursing as an accreditation standards agency for accreditation of schools of nursing; relating to the Committee on Retirement Savings Plan authorized to be established with the Wachovia Bank & Trust Company with recommendation of the announcement of the plan to be deferred into 1965. On motion, duly seconded, and on vote carried the report of the Commissioner on Professional Services was approved.

A further recommendation of the Committee on Eye Care that a resolution be passed prohibiting hospitals from requesting specialists to treat emergency patients out of their field of medical specialty in emergency rooms was, on motion duly made and seconded, tabled by vote of the Executive Council.

Discussion was had on the AMA request that the Society rescind the resolution of 1963 enacted by its House of Delegates on the recommendation of the Committee on Eye Care relative to the appointment of Ophthalmologists on Federal Armed Forces Boards of Medical Determination of disability. Defacto AMA has been confronted by Federal Agencies that while such Ophthalmological representation is not available that consultants from Walter Reed Hospital are available to the Boards. On motion the AMA communication and request for rescinding action was regarded as information and, on second, the motion carried by vote of the Executive Council.

Commissioner Lindsey next presented the combined Medical Society, Hospital Association and medical members of the N. C. Nurse Board Ad Hoc Study Committee on the Critiques of the Ray Brown Report to the N. C. Board of Higher Education which critiques embody the general sense of the Ad Hoc Study Committee recommendations that there are certain recommendations in the Brown Report that would tend to downgrade, discredit, and perhaps render extinct the diploma schools of nursing, which is contrary to the traditional policy of this State Medical Society and therefore the adoption of the Critique by the Exexcutive Council would be an endorsement for support at all levels of nursing, including diploma schools. A motion was made to approve the Critique of the Roy Brown Report as recommended by the Committee on Nursing of the Society. The motion was seconded and on being put the motion carried.

Commissioner Lindsey next presented the premise of the "Guidelines for Nursing Education' developed by a state-wide group of nurses quoted as follows: "A projected system of education for nurses in North Carolina is based on the principle that nursing must be located in and controlled by an institution whose stated primary purpose is education beyond the high school. The immediate implementation of this principle would result in two levels of basic preparation for nurses, (1) within the senior college or university for professional education, and (2) within the junior college or comprehensive community college for technical education." The Ad Hoc Study Committee observes this to eliminate forthwith any consideration of

diploma schools of nursing and led to the development of a Critique on the "Guidelines for Nursing Education" which the Committee on Nursing recommends the Executive Council approve. On motion, duly seconded, the Critique on the "Guidelines" was adopted by vote of the Council.

Commissioner Lindsey further reported the recommendation of the Committee on Nursing that some effort be made to obtain State funds to assist Nurse Training Schools in the form of bricks and mortar, nurses to teach and support of student training in hospital schools of nursing. On motion, duly seconded and by vote carried, the report of the Nursing Committee was accepted.

(The Executive Council recessed at one-five o'clock P.M.)

The meeting of the Executive Council reconvened at two-twenty o'clock P.M. with President Raiford presiding.

President Raiford recognized Commissioner Thomas Thurston of the Public Service Commission who reported that each of eleven committees had met and he reported: relative to Anesthesia Study Committee continued survey from Chairman Hollandsworth's location at U.N.C.; relative to Committee Advisory to Department of Public Welfare working in harmony with the Director, Mr. Russell Chambers, and Medical Director, Dr. Cynthia Hardison; relative to Maternal Health Committee recommendation that hospital staffs by-law committees be advised to revise staff by-laws on sterilization to contain the three elements of consent being given to the performance of such operations, that the time within which the operation is performed be stated and that statutory conditions prescribed for compliance be met in the establishment of legality of sterilization and in not altering the medical indication for such procedure and deferred a recommendation of family planning project and contraceptive clinic being conducted at Bowman Gray School of Medicine for discussion with the Executive Council to February 1965; relative to activities of the Committee on Cancer in recommending an additional \$100,000 appropriation of the 1965 General Assembly to support twelve month funding of State Board of Health Cancer treatments of certified indigents and to extend the field of chemotherapy to these indigents; relative to Committee on Occupational Health recommendation to distribute the article by Henry Howe entitled "A Small Industry: An Opportunity for the Family Physician" and requesting County Health Departments to emphasize occupational health in their local medical societies; relative to the activities of the Committee on Venereal Disease in recommending that hospitals be cited to requisition routine blood tests for syphilis on all admissions, that the medical schools work with the State Board of Health on adequate clinical material for teaching and to further medical education in this area, observed the experience of penicillin resistance with

recommendation for increased dosage needed for treatment and possibly attention to serological performances on these cases; related to Committee on Physical Rehabilitation recommendation, for co-operation with vacational rehabilitation administrators, the continued tabulation of rehabilitation cases, and a nomination of Dr. J. H. Shuford for the Handicapped Award to a Physician for services; related to the Committee on Child Health and Poliomyelitis report of polio vaccination campaigns in 83 counties with estimated aggregate feedings of 2,750,000 with immunizing vaccine and 17 counties yet to effect a late fall campaign now organized, PKU being recommended for the new boom in prevention of mental retardation and recommendation that battered child legislation be considered; relative to Committee activity by the Committee on Mental Healh and Medicine in Religion wih emphasis on concern with school residence and kindergarten programs in the Department of Public Instruction; relative to the activities of the Committee on Chronic Illness in the area of "shop talk" on problems of Home Care, forms for evaluation in medical examinations of patient in nursing homes, recommendation for tuberculin skin tests on children under age 18; relative to the activities of the Committee on School Health as to a recommendation in school sports regulating pregame practices and non-contact during first three days of practice without pads or heavy equipment, limiting practice periods to one per day avoiding heat periods, that immunizations in schools be followed up each fourth year, follow-up on small pox and diphtheria tests, that progress is reported on Medical Society-Dental Society approach to an advisory council on school health problems and finally reference to educational programs in the field of sex education now under consideration by other committees of the Society and to extension of health education through the twelve grades of public school; relative to the Cancer Committees support of the North Carolina Cancer Institute upon which Dr. D. E. Ward elaborated as to progress. On motion duly seconded the report of Commissioner Thurston was upon vote accepted.

On motion, seconded and on vote carried, Dr. Jacob Harrison Shuford was nominated for recognition for the Physicians Award on the Physically Handicapped. Suitable methods of recognition were authorized to be carried out.

On motion, duly seconded and on vote carried, physical education through the twelfth grade was approved in principle by the Executive Council.

On motion, duly seconded and on vote carried, the Executive Council referred recommendation on each fourth-year immunization to the Legislative Committee to study.

A motion was made to refer the recommendations on sex education to the Committee on Maternal Health. The motion was duly seconded and upon vote carried. On motion, Dr. Jacob H. Shuford was nominated to the House of Delegates for Honorary Membership in perpetuity. The motion was duly seconded and on vote carried.

President Raiford next recognized Commissioner David G. Welton (a member of the Executivee Council) for report from the Public Relations Commission it being indicated that seven of nine committees had met and developed reports of recommendations as follows: related to Committee on Hospitals and Professional Relations in reference to Dr. Robert Cadmus July 1963 study for the Spruce Pine Hospital Board of Trustees (involving a physician's relationship) about which the Committee expressed concern on the manner and timing and extra legal access exercised by a member of the State Medical Society: relative to the structure for a utilization-of-hospital questions, recommending the matter be referred to either the Committee on Insurance Industry Liaison or to Committee on Blue Shield and that hospital staff to which physicians belong should take cognizance of the problems of utilization for which the Executive Council would make a statement for dissemination; relative to the Committee on Medical-Legal Affairs recommendation of standardized report form by physician to attorney of (non-insurance) medical information be approved and to a second recommendation, in reference to physicial sale, compounding and dispensing of drugs through third persons as involving a law violation as well as jeopardizing the professional liability coverage of the physician as propounded by N. C. Attorney General opinion, to the effect that the excerpted opinion be disseminated as the Executive Council should direct, (a similar opinion had been expressed by the Committee on Pharmacy through the P. R. Bulletin); relative to the Committee on Public Relations citing observance of National Community Health Week, information packet distribution to local societies, exhibit plans for State Fair, continued support of Science Fair, plans for county Society officer conference 1965, the AMA Education Campaign and supporting allocations, and a speakers training program offered by S.K.F. limited to 25; relative to activities by the Committee on Rural Health and recommendations on farm and pond safety, agricultural poison labeling, pollution and sewage and tetanus immunization; relative to Committee on Insurance Industry Liaison which recommends that insuring company or association reject payment health insurance claims where not signed or validated by attending physician, that utilization be vested in no more than one committee of the society, that Society Seal appear on CRS stationery; relative to the Committee on Pharmacy and its recommendation of 50% support of plan for state-wide Medical-Pharmacy Conference as follow-up of AMA Conference of 1964; relative Committee Advisory to N. C. Department of Motor Vehicles name change, a public

statement of joint program on license revocations, agree to print by Licensing Division the back new drivers license application medical history volunteered by driver as to blood-type and Rh-date Tetanus immunization—regular drugs taken—specific allergies; relative N. C. Association of Professions as to approved budget requests and continued growth and unity of the professions in N. C. On motion, duly seconded and on vote carried, the report was accepted.

On motion, duly seconded, a special recognition of emphasis by communication to hospital staffs on utilization was authorized by the Executive Council, and on vote, carried.

On motion, second and on vote carried, the Executive Council authorized the Committee on Pharmacy Liaison to release information to the membership alerting dispensing practitioner to a ruling by the Attorney General of North Carolina under which direct employee dispensing is contrary to law and affects liability coverage.

A motion was made to change the name of the Committee on Traffic Safety to the title of Advisory to N. C. Department of Motor Vehicles. The motion was seconded and on vote, carried.

A motion was made to authorize a joint statement in explanation of physician-motor vehicle collaboration in determining motor driving capacity of certain drivers be signed by the President and Commissioner Edward Scheidt of the Motor Vohicles Department. The motion was seconded and on vote, carried.

On motion, duly seconded, the subject of a utilization committee was deferred by vote.

On motion, duly seconded and on vote carried, the use of the Society Seal on Claim Review Service of the Insurance Industry iLaison Committee was authorized.

Routine interim district Councilor reports were made and none required Executive Council action.

President Raiford presented a progress report on the organization of the Presidents of State Medical Societies. He further stated this action in deleting five committees from the Society committee structure.

President Raiford referred to the Fall Committee Conclave, its usefulness and pointed to a number of Committees deliberately not participating and called for all committees to participate in the future. He referred to functions and offered some suggestions to the council regarding their structure and tenure.

Delegate M. D. Hill, M.D., reported on the Annual Meeting of the AMA House of Delegates as information without action by the Executive Council. Delegate Amos N. Johnson, M.D., supplemented the report, particularly on tobacco labeling proposed by a Louisiana delegate.

A motion was made to authorize the President to instigate a calendar in the Journal to assist the avoidance of duplicate meeting dates. The motion was seconded and on vote, carried.

The Executive Director reported his investigation of central billing of State and American Medical Association dues and indicated the billing as a simple process could be performed on the Addressograph with some revisions. President Raiford suggested deferring county society billing until the Officers Conference. Theer were various discussions. On motion, duly seconded and caried, solicitation of information and preferences from county society officers at the February meeting was authorized.

On motion, duly seconded and carried, the Finance Committee, plus four—the past-president, the President, the President, the President-elect and Secretary—is constituted a committee of authority to confer with Internal Revenue Service on tax questions.

A resolution present from the American Occupational Therapy Association was read. On motion, duly seconded and carried, this resolution was deferred to AMA action to which the resolution also is offered.

Secretary Charles Styron presented and discussed correspondence from S. H. Justa, M.D., and responses made to same regarding the Annual Sessions of 1964 criticized by Dr. Justa, to which the Executive Council gave approval in general.

A letter from former Tenth District Councilor William A. Sams, M.D., was presented to the Executive Council in which thanks and appreciation were expressed to the entire Council for the opportunity for service in the Council for so long a time.

A communication from the Health Planning Council of Central North Carolina was read. On motion, duly seconded and on vote carried, the Executive Council endorsed the Planning Council with an expression of best wishes.

The favorable ruling of the N. C. Attorney General relative to physician directed passing of Levine Tube was accepted as information.

A communication from the President of the Wake County Medical Society relative to staffing vaccine was, on motion made, duly seconded and on vote carried, received as information.

The Executive Council adjourned at four forty-five o'clock p.m.

THE EXECUTIVE COUNCIL MEETING SATURDAY MORNING SESSION

FEBRUARY 7, 1965

A meeting of the Executive Council of the Medical Society of the State of North Carolina, held at the Carolina Hotel, Pinehurst, North Carolina, was called to order at nine-ten o'clock by Dr. T. S. Raiford, President of the Society. Dr. John Rhodes gave the invocation.

In the absence of Dr. Styron, the roll was called by Dr. Poteat, and a quorum duly declared. Dr. Raiford commented on the heavy load of detail matter being brought to the Council for action, noting that much of it was being brought for information only and so should not slow the Council much.

On motion by Dr. Beddingfield, the reading of the minutes was dispensed with, reference being made to the existence of the reporters' transcript for any questions.

In the absence of Dr. Faison at the AMA meeting, Dr. John Rhodes gave the report of the Finance Committee. He noted that the Auditor's Report for 1964 showed a budgeted income of \$250,-980 and an actual income of \$247,453; a budgeted expense of \$243,000 and actual expenditures of \$228,732, for an operating surplus of \$18,700. Dr. Rhodes noted that in the previous year almost all committee budgets were overspent, whereas in 1964 most committees stayed within their budget. The only major budget deficit was in Journal advertising, which showed a drop of \$9,000 from budgeted income. Mr. Barnes commented on the depressing effect of the Kefauver hearings and the recent Food & Drug regulations on pharmaceutical advertising. Mr. Barnes also alluded to the meeting in Washington in October with the General Counsel of the Pharmaceutical Manufacturing Association regarding the prospects for Journal advertising as opposed to the new controlled circulation publications that have apparently cut into advertising in regular medical journals.

Dr. Rhodes reported a dividend return of approximately 6.1% on invested funds with a book value of \$153,000.

The Finance Committee recommended approval of requests from the Rural Health Committee of \$175 for a statewide Rural Health Conference and the Marriage Counseling Committee for \$350 of headquarters services and mailing expenses to hold a Marriage Counseling Symposium. On motion by Dr. Ward these were approved.

The committee asked the headquarters staff to proceed with cost estimates for central billing, and that contributions for AMPAC and MedPac be listed on the billing sheet as voluntary items. These two recommendations were deferred for later action.

Dr. Lloyd Thompson presented the Report of the Subcommittee on Children's Services and asked that the report be published under the joint sponsorship of the State Medical Society and the Mental Health Association. On motion by Dr. Beddingfield, seconded by Dr. Lynwood Williams, the report was approved in principle, with the proviso that specific action items should be brought back to the Council before adoption.

Dr. D. A. McLaurin on behalf of the Nursing Home Advisory Committee and the Chronic Illness Committee asked the Council to approve some authority to develop a sound mechanism for determining whether physical examination reports for nursing home cases are being properly and adequately handled. On motion by Dr. Reece, seconded by Dr. Bridger, the report was approved. Dr. McLaurin noted that the patients are being examined, but that there is no way of checking to see if the recommendations of the physician's are being followed, especially when the physician's report calls for removal to a nursing home or hospital from a rest home.

Dr. McLaurin presented a recommendation that the Medical Society recommend that the Department of Public Welfare pay nursing homes for the care of welfare recipients at a rate sufficient to cover the reimbursable costs of such care, up to a stated maximum figure. On motion by Dr. Paschal, seconded by Dr. Brinn, the motion carried.

Dr. Koomen of the State Board of Health reviewed the proposed program of health examinations and corrective actions proposed in North Carolina under the Economic Opportunity Act and the Manpower Retraining law. This was given as information from this just-beginning activity, and on motion was received as such.

On motion by Dr. Paschal, seconded by Dr. Ward, the Council accepted as policy a resolution from the School Health Committee as follows:

The Medical Society actively seeks the expansion of the present health and physical education program to require 12 years of health and physical education for all boys and girls in the public school system of our State; and the committee further requests that the Executive Council inform the High School Athletic Association, the State Department of Public Instruction, and other appropriate agencies of its support in this undertaking.

Somehow this did not get acted on in September. I would appreciate the support of the Council in this. We would assign no legislative priority, however, to this action.

Dr. McLaurin made a progress report concerning action to get an advisory committee for the state school health program appointed by Governor Moore.

President Raiford commended Dr. McLaurin for his fine job after stepping into the vacancy left by the death of Dr. Frank Barnes.

President Raiford made the following recommendation concerning structure and function of the Utilization Committee being set up.

The President shall appoint a Utilization Committee consisting of nine members as follows: Two members each from (a) the Blue Shield Committee; (b) the Committee Liaison to the Insurance Industry; (c) the Committee on Hospital and Professional Relations; three members at large, one of whom shall be Chairman.

The function of this Committee shall be to represent the Medical Society in a liaison and advisory capacity to similar committees representing the North Carolina Hospital Association, the North Carolina State Committee of the Health Insurance

Council, and representatives of state agencies whom the Governor may see fit to designate, including the Insurance Commissioner of the State of North Carolina, in studying the problem of over-utilization of health insurance and formulating policies to rectify and prevent abuse in that area.

It is further recommended that if this Committee is found to have a continuing necessary function three years after the date of its activation, it be made a constitutional or standing committee with a designated structure and system of membership rotation.

On motion by Dr. Welton, seconded by Dr. Poteat, this proposal was adopted. The following were appointed by President Raiford to the new Utilization Committee:

Dr. Fleming Fuller, of Kinston, member at large as chairman; Dr. Warner Wells, Chapel Hill; Dr. W. M. Nicholson, of Durham—all three members at large.

Representing the committee liaison to the insurance industry, Dr. Frank Jones and Dr. Barry Hawkins; the Committee on Hospital and Professional Relations, Dr. J. S. Raper and Dr. Glenn Newman; and for the Blue Shield Committee, Dr. Bradford, of Charlotte, and Dr. Kroch of Asheville.

Dr. Joseph May presented a resolution relating to the teaching of sex and family life planning in the public schools. He stated that he felt the State Board of Education and Department of Public Instruction would do far more in such education if they had a positive statement of support from the Medical Society. The following resolution on motion by Dr. Ward, seconded by Dr. Paschal, was adopted:

Whereas, we find ourselves in a permissive society which encourages unrestrained expression of self, there is much evidence that sex irresponsibility among teenage children and young adults is a fast-growing social illness; there is a recognition by enlightened people for the need of a program in sex education to be taught beginning in the lower public school grades before children become emotionally involved in sex matters.

Whereas, a majority of high school girls will be married by their eighteenth birthday, it seems only practical that a course in marriage responsibility should be taught in the final year or two of high school.

Whereas, the medical profession is among the most learned in the matter of sex anatomy, physiology, and emotions, we recognize the responsibility of the medical profession to share this knowledge with others who may disseminate it at the proper levels in the educational system.

BE IT RESOLVED:

1. That the Medical Society of the State of North Carolina, recognizing the need for sex education in public schools, direct the formation of a committee of interested and knowledgeable people on the subject of sex education for the purpose of studying

the possibilities of formulating a program of instruction for public school teachers by qualified physicians throughout the various parts of the State.

2. Since the project will involve the educational system in the State of North Carolina it would be deemed wise to establish immediate contact with the State Board of Education in an effort to solicit their cooperation in the joint effort to revise the classroom instruction and to formulate material into graded courses for sex education from elementary grades through high school level, and to establish marriage courses in high school.

Dr. Henry O'Roark presented a report of the Forsyth County Family Planning Group and the various services offered by the Forsyth County organization. Dr. O'Roark recommended that the County Health Department be the best organization for directing and initiating a program if it is to have wide impact, rather than just the lowest economic groups as where the program is entirely a Welfare Department function. The Forsyth program includes a complete health examination, uncovering many cases of health problems not even suspected by the patient; a complete medical history; and counseling as to all aspects of family planning. The Health Department furnishes personnel and facilities; the Welfare Department the interuterine contraceptive devices or oral contraceptive pills for all welfare patients who will participate.

In the first six months Forsyth enrolled 220 Negro and 25 white patients. Fifty-nine dropped out; 13 others were either pregnant at examination or had no need for a contraceptive device. Of the patients participating in the program, none have become pregnant during the six months.

Dr. O'Roark emphasized the necessity of informing and gaining support of the local press before initiating the program.

On motion by Dr. Beddingfield, seconded by Dr. Bridger, the report was accepted and approved.

On motion by Dr. Paschal, reporting for Dr. Hamilton, the Council approved and endorsed the Relative Value Schedule of California for use in North Carolina. The 1961 schedule was to be discontinued from further distribution, with the California Scale replacing it as the official schedule. Details of cost and authority for dissemination were vested in the staff.

Dr. John Truslow gave a progress report for the North Carolina Medical Center Study Commission. His report briefly outlined just what his group has set as the limits of their investigation, namely "to make a detailed and exhaustive study in regard to doctors, surgeons, nurses, technicians, anesthetists and other medical personnel. The study is to include the financing and the maintenance of this training, and the Commission is to report back to the General Assembly with respect to all matters relating to the establisment of medical centers as set forth in the Joint Resoluion."

The Commission will meet with the ad hoc committee of the Medical Society during the Annual Session.

On motion by Dr. Beddingfield, seconded by Dr. Ward, Dr. Frank Jones was appointed to transmit to the Insurance Commissioner and urge acceptance of the new simplified Health Insurance Claim Form submitted by the AMA and the Health Insurance Council.

A resolution was accepted from the Beaufort-Hyde-Martin-Washington-Tyrrell Medical Society advocating additional medical training facilities in eastern North Carolina. The resolution was referred to the ad hoc committee.

Dr. Beddingfield gave information relative to a Channel 9 TV show advocating a medical center at Greenville, and Dr. Rhodes gave information on a forthcoming Channel 4 TV show called "Encounter" in which Dr. Rhodes would be a panelist discussing "Medicare"-the King-Anderson bill.

On motion by Dr. Paschal these items of information were accepted.

Dr. Hollister brought information relative to an invitation from Pinehurst, Inc., to hold the 1967 convention at Pinehurst. There being some unresolved questions and the matter of a tentative commitment to Asheville, this was referred to the Arrangements Committee, on motion by Dr. Shaffner, with instructions to report back to the Council at its May Meeting in Charlotte.

On motion by Dr. Reece a recommendation by Dr. W. L. Wilson that the Council continue the work of the ad hoc committee on Occupational Health in trying to work out an arrangement for complete physical examination of Medical Society members at our Annual Meeting. Dr. Wilson stated that facilities made such an examination at the Charlotte meeting impractical.

Dr. Wilson presented a request for an action, affirmative or otherwise, by the Council on a request for routine chest x-rays for the State Association of County Commisioners during their annual meeting in Asheville. The Council discussed whether the health advantages of finding unsuspected disease offset the advantages of such checkups being done by the family doctor. On motion by Dr. Poteat, seconded by Dr. Beddingfield and passed to endorse the program in principle, the motion carried.

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Dr. McMillan presented proposed changes in the Constitution and By-Laws as follows:

To amend Chapter 15, Section 5, page 39—Each county society shall be the judge of the qualifications of its own members, but as such societies are the portals to this Society and to the American Medical Association, only reputable and legally registered white physicians who are practicing or who will agree to practice, non-sectarian medicine, shall be admitted as active members; provided that other reputable and legally registered physicians practicing non-sectarian medicine may be admitted as

Scientific Members with the privilege of attending and participating in all scientific and business sessions of the Society, and of voting and holding office. No physician shall be admitted to this Society between a date following ten days after the Annual Meeting of the Society and the date of the next Annual Meeting of the Society except by special action of the Council.

Now, after the word "member" add: "a county society may admit other members upon such basis or classification as it may determine."

And then, Article IV, Section 2—of the Constitution, this is—by inserting between the words: "The members" the word "active" and by striking out the words "other than the scientific members" following the word "member."

Where it says "Active members of this Society shall be members other than the scientific members of the component societies and those physicians who are admitted by the Executive Council as hereinafter provided"—we want to put there now, inserting between the words "the members," and say "the active members of this Society"—and striking out the words "other than the scientific members" following the word "member."

"The active members of this Society shall be members other than the scientific members of the component societies and those physicians who are admitted by the Executive Council as hereinafter provided."

Now, we are amending this Article IV, Section 2, by inserting between the words "the members"—
"the active members of this Society"—and by striking out the words "other than the scientific members" following the word "members."

These changes would allow a component Society to take in anyone they desire as a member, whether a reputable licensed physician or not, but would limit "active members" to just such physicians. Any person an "active member" of a component society would be an "active member" of the State Society. Theer would be no other class of membership in the State Society.

On motion by Dr. Welton that this be published in the February *Medical Journal*, if possible, or otherwise circularized, in a simple form with explanations, before the May meeting. Seconded by Dr. Reece and carried.

Another change recommended by Dr. McMillan's Committee on Constitution and By-Laws would rewrite Chapter IV, Section 11 of the By-Laws to read as follows:

The House of Delegates shall have authority through the Executive Council by majority vote of the Council, a quorum being present, to elect to membership any reputable and legally licensed physician who applies directly to the Society for membership as provided in Article V of the Constitution when such physician has been definitely refused admission to the local society and he has appealed to the Executive Council for membership

and where, after hearing, the Council is convinced that such physician is eligible for membership in the State Society and that it is impossible to reconcile the local society to admitting him. The Executive Council shall certify the election of such physician to the Secretary. A member so elected on payment of annual dues and assessments for the current year shall be entitled to the rights and privileges of membership as provided by Article IV of the Constitution.

This too was ordered circularized or published for the membership.

The meeting adjourned for lunch.

SUNDAY AFTERNOON SESSION

February 7, 1965

The meeting reconvened at two-twenty o'clock, President Raiford presiding.

The Council discussed the TV statements supporting King-Anderson Social Security medicine made by Dr. Eaton and Dr. Watts of the Old North State Medical Society, as well as the appearance of Dr. Johnson and Dr. Beddingfield on the Wilmington TV station stated the reasons for the State Society stance. Texts of the statements on both sides were offered for dissemination to the delegates before the State Meeting.

Information was received that Wilkes County planned to receive a Negro into full membership as soon as the State Society would so allow.

Dr. Richard Kelly reported that the mass oral polio immunization program had reached all 100 counties, with about 2,801,000 persons participating.

The Child Health Committee recommended a program whereby the State Board of Health would send an immunization questionnaire along with each birth certificate, and recommend that immunization begin if it had not already started.

The Child Health Committee also recommended that the newborn test for PKU be endorsed and cooperated with. The Committee presented the revised AMA-endorsed legislative proposal to permit physicians to report with immunity cases of child abuse, and to require the agency reported to to take action.

Finally, Dr. Kelly asked that the State Society take the lead in establishing health standards for day schools and nurseries.

The report was accepted and endorsed on passage of a motion made by Dr. Beddingfield, seconded by Dr. Bridger.

Dr. Hollister presented a report of the Negotiating Committee relative to re-negotiation with Veterans Administration of the fee schedule and other aspects of veterans' care, as follows:

What they wanted was our permission to use the 1960 Relative Value Fee Schedule of California to base their future fee scheduling on. They are doing this on a nation-wide basis, but they are negotiating state by state.

They asked us if we would be willing to negotiate an increase in the out-patient fee schedule from \$4 per visit to \$5 per visit.

They said: Why don't we just renegotiate the whole fee schedule? That includes all types of fees—laboratory fees, surgical fees, medical fees, psychiatric fees, radiology fees, and so on. They were very much interested in giving us about, approximately, a 40 per cent increase in the entire schedule, with 17 exceptions.

Thirdly, they want to negotiate a contract with the Medical Society, a letter agreement with the Medical Society to deal feewise directly with us rather than through a third party—that is, hospital care—as they have been dealing with before.

The Committee's recommendation, as far as Dr. Poteat and I were concerned, was: Go ahead and negotiate with them, and allow them to use the relative value schedule to base their fees on. We certainly don't have any objections to an over-all increase in the fee schedule, and as far as we were concerned, the Committee recommended that we deal directly with the Veterans Administration, instead of through a third party.

Tom Daimler said in a letter to me that he was suspicious of the VA, and that he thought perhaps it would be well not to commit the State Medical Society, as far as any letter of agreement was concerned.

However, the Committee on Negotiations was charged with making some decision about this, and I think on the basis of the two-to-one decision we would recommend, first, that we do negotiate directly with the Veterans Administration, as far as these are concerned; and, secondly, that we allow them to utilize the relative value schedule. They have already negotiated this with several states; and, thirdly, that we accept their offer of an increase in the fee schedule, which would amount to approximately somewhere between 20 and 40 per cent more than where it was previously.

After considerable discussion, on motion by Dr. Beddingfield, seconded by Dr. Poteat, the recommendation was approved and the letter of intent to the Veterans Administration approved.

The Legislative Committee reported the beginning of a new publication, "Legislative News," to be mailed periodically to the membership to keep everyone abreast of latest developments, and suggesting co-ordinated activities.

The Committee was pessimistic about the chance of heading off King-Anderson-type legislation by the 1965 Congress, but encouraged by the response to the AMA-sponsored "Eldercare" approach. Dr. Beddingfield mentioned the schedule of Social Security tax under "Medicare" that would be at least 10.4% by 1970, with self-employed physicians included.

Dr. Beddingfield reported that on the basis of

last fall's newspaper campaign of "Health Care for Those Over 65" the AMA proposed to match funds with each State Society for a spring campaign geared to the particular situation, and that nothing be run in the state without prior approval by the State Society. The matching funds can be up to \$2.50 per North Carolina member of AMA.

On motion by Dr. Shaffner, seconded by Dr. Bridger, the Council approved the conducting of a campaign by the Legislative Committee using funds from the committee budget, matched by AMA funds, up to the maximum \$7,000 plus allowable on the basis of membership.

On the State Legislative level, Dr. Beddingfield recommended a watch and wait attitude on HR 10 which would, in effect, allow double recovery in a malpractice suit under Workmen's Compensation. The Committee feels that though a bad principle is involved, any overt action would be inappropriate.

Regarding the proposed Nurse Practice Act, the Committee recommended that the Society go on record as accepting the latest revision of the Nurse Practice Act as presented to them by the attorney for the State Board of Nursing, and that we no longer oppose the nominee system of choosing the members of the State Board of Nursing.

Motion by Dr. Welton, seconded by Dr. Rhodes, the report was accepted, along with the recommendation

Finally, the Committee recommended support for a bill to amend certain parts of the North Carolina General Statutes relating to the right of an individual to dispose of his own body, or parts of his own body, for tissue or organ transplant after his death.

Motion by Dr. Paschal, seconded by Dr. Welton, and passed.

Dr. John McCain recommended the acceptance of contributions of \$4,250 from AMA and the North Carolina Health Association for sponsorship of the Blue Shield Conference for Physicians to be held March 11 and 12. Motion by Dr. Paschal, seconded by Dr. Rhodes, and accepted.

Dr. McCain's report on a new pamphlet concerning ways of gaining admittance to mental hospitals, and his activities on a nursing accreditation committee was received as information.

Dr. Millard Hill in brief remarks commented on the actions of the AMA House of Delegates and the work of Dr. Donovan Ward who became president of AMA at the death of Dr. Welch. He urged more encouragement of the Auxiliary, and commended the political acumen of SAMA members from North Carolina, including John Packer of Clinton, the current national president of SAMA.

Dr. Hill alluded to the candidacy for AMA president of the Congressman from Missouri, Dr. Hall, calling him a "real crusader."

On motion by Dr. Ward, seconded by Dr. Reece,

the Council approved the draft of a resolution on Honorary Membership for Dr. Jacob Shuford.

Dr. Bridger moved the acceptance of a Finance Committee recommendation that the Society underwrite the cost of bus transportation for two Auxiliary tours scheduled for Charlotte, estimated at \$175. Seconded by Dr. Ward and passed.

Motion by Dr. Ward, seconded by Dr. Bedding-field, and passed, to accept with pleasure the invitation of North Carolina National Bank for the Council and Commissioners, the staff of Council, and wives to be guests for dinner in their penthouse suite in Charlotte after the Saturday meeting of the Council in May.

Motion to extend temporary honorary membership to Dr. Jesse Lee Cavener while he serves as Medical Missionary in India. Carried.

Motion to grant a request from McDowell County to be transferred from the Ninth to Tenth District, the Councilors involved having approved, was seconded and passed.

Motion by Dr. Rhodes, seconded by Dr. Ward, and passed to authorize the headquarters staff to pro-

ceed with the installation of TWX equipment, to be paid for by AMA, if in their judgment it would be effective and valuable in their activities.

A request from Dr. J. Harold Brown of Civil Aviation Medical Association for establishing of a section of aviation medicine was deferred for lack of any such specialty known in North Carolina.

On motion by Dr. Rhodes, seconded by Dr. Welton, the President and Executive Director were authorized to establish an appropriate special recognition for Dr. A. C. Bulla, honoring his long and outstanding service to medicine, for the May Meeting.

Motion by Dr. Ward, seconded by Dr. Welton, and carried to extend an invitation to AMA to hold the 1967 National Rural Health Conference in North Carolina, probably in Asheville or Charlotte

Motion by Dr. Shaffner, seconded by Dr. Ward, to leave the matter of running heads in the Roster to the headquarters staff. Passed.

On motion by Dr. Poteat, seconded by Dr. Ward, the meeting adjourned at four forty-five o'clock.



Minutes of Executive Council Meetings

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA SATURDAY MORNING SESSION

May 1, 1965

The regular annual meeting of the Executive Council of the Medical Society of the State of North Carolina was held in the Kuester Room of the Queen Charlotte Hotel, Charlotte, North Carolina, convening at 9:05 a.m., Dr. T. S. Raiford, President of the Society, presiding.

The meeting was called to order, and Dr. John S. Rhodes rendered the invocation. After roll call, Dr. Styron declared a quorum present.

The abridgement of the minutes as printed for presentation to the membership were approved.

Dr. W. M. Nicholson, on behalf of the Editorial Board, pronounced the Journal in excellent condition in the hands of the new Editor and Associate Editor. He reported that no money was being earned, but advertising up slightly from 1963. Dr. Nicholson reiterated the position of the Editorial Board opposing free advertising unless it had promise of economic benefit to the Journal or the Society.

On motion by Dr. Styron, seconded by Dr. Welton, the report was accepted.

Dr. Raiford brought to the Council an agenda of items, mostly trivia, that had been discussed and disposed of by an informal meeting of the immediate Past President, the President, the President-Elect, the Constitutional Secretary, and Executive Director in the headquarters office on the first of April.

Dr. Raiford asked the Council to approve this type of "Executive Committee" arrangement to handle routine matters between meetings of the Executive Council. He explained that the purpose was to expedite handling of routine and trivial matters that technically the President could handle alone, but on which he would like the advice and concurment of other officers of the Society.

As a sample of the type items discussed, Dr. Raiford noted (1) a communication from Dr. Durwood Hall announcing his candidacy; (2) the commendation of the Wake County Society and Wake Chapter of AGP for providing medical services for members of the General Assembly; (3) the program of draft rejectee investigation; (4) the forwarding of a grievance to the chairman of the Grievance Committee; (5) discussed the pending Chiropracty Bill; (6) reviewed a documentary film prepared by Hospital Care for TV presentation; and (7) a request from the Osteopathic Society for a liaison committee.

Dr. Raiford asked the Council to take some action on the request of the Osteopathic Society,

noting that in the request no specific function or course of action was outlined for the Committeee. On motion by Dr. Shaffner, seconded by Dr. Benton, the appointment of such a committee was voted to be held up until a specific purpose for such a committee could be established.

Regarding the Health Careers program and their fund-raising drive, on motion by Dr. Poteat, seconded by Dr. Welton, it was decided to co-operate with the Hospital Association by furnishing Addressograph facilities for mailing contribution requests to doctors, but that the Society would take no part in any such campaign other than approve it in principle.

Dr. Poteat gave the following report on the North Carolina Educational Council for National Purposes.

I wish to acquaint you with the Institutes on Constitutional Democracy and Totalitarianism held last summer at East Carolina College in Greenville and Appalachian State Teachers College at Boone.

The institutes were designed to teach, by dramatic contrast, the merits of democracy as opposed to foreign ideologies hostile to the American way of life. Outstanding authorities across the nation were recruited to instruct approximately 100 students during four weeks of residence on the two campuses.

A majority of those attending were teachers who are now applying such learning in their own social science classes at the high school level, thus extending the reach of the course to thousands of students.

The course is conservatively oriented and consistently supports the traditional American concept of an economy based on reward commensurate with individual initiative and demonstrated worth in service to the consumer. It reveals the many fallacies of the socialist philosophy. In the opinion of those who took the course, those who taught it and numerous outside, objective monitors, these Institutes were highly successful and should be continued this year as an ally of the economic and political system under which we are privileged to live and work in this free country.

Sponsored by the North Carolina Educational Council on National Purposes, the institutes last year were financed by private foundations, by business corporations and banking institutions of the state. The Council asked no state nor federal funds and is not now seeking such. It does appeal to professional men to join with last year's supporters to provide sufficient financial backing to carry on.

Socialistic infringement upon our free enterprise economy has been a growing concern of our Medical Society to which these Institutes should be a welcome ally.

This is a personal appeal for substantial support

of the Council to assure the continuance of this worthy endeavor. It is my belief that our profession could find a natural channel for generous gifts to the Council by sponsoring local students to attend these Institutes through scholarships financed by the local medical society. Each scholarship would require not more than \$250., and each medical society could determine the number of scholarships it would provide on the basis of response within its own membership.

To me, the beauty of scholarships, as opposed to direct cash contributions to the Council, is the direct identity with this worthy cause it would afford our profession. The experience of past Institutes has shown that those who attended, sponsored by local organizations and the Council, have made themselves available for public meetings of civic, fraternal or religious groups in addition to their classroom work and that they have been very effective in this respect.

I sent a copy of that to the president of every County Medical Society in the State from me personally, not as an official of the State Medical Society, and asked them to present it to their County Medical Society, and if they wished to sponsor students to go to these institutes, they could take it upon themselves to do it.

I don't mean that we need to budget anything for it at all, but I think we should certainly support this thing in principle, and I would like very much to see an editorial in our Medical Journal on it.

The people who are running it are just the finest people that you can find anywhere in this State.

Comments from the other Councilors indicating wholehearted approval, on motion by Dr. Beddingfield, seconded by Dr. Williams, the Council approved the report and affirmed the action of the "Executive Committee."

The Council re-affirmed its action in February, instructing the Executive Director to proceed with central billing of state and AMA dues directly to the members, with the inclusion of county and district dues being added on request of the component societies. When a component Society desired to be included, its dues would be collected by the headquarters office and remitted to the local unit.

On motion by Dr. Beddingfield, seconded by Drs. Benton and Paschal, the Council instructed the headquarters staff to proceed as instructed by the House of Delegates in 1964, and to include on the same bill a statement for a voluntary contribution to AMPAC and MEDPAC of \$20. This voluntary contribution was to be clearly so marked.

Discussion clarified that this procedure would in no way affect a person's eligibility or status as a member of either a component society or the State Society, since dues for State and AMA would not be accepted except from regular active members.

Dr. Poteat assumed the Chair for Dr. Raiford to explain why the committee favored putting AMPAC dues, a voluntary item, on the regular central billing form, but asking a very clear separation

(Dr. Raiford resumed the Chair.)

Dr. Kernodle reviewed his work with AMPAC and cited experience in Pennsylvania and other states showing that including AMPAC on the regular dues billing increased participation from 25% to over 90%. He stated that a very real need for hard cash is now in evidence, and that the big positive public response to the Eldercare project had demonstrated that there is an opportunity to prevail to some extent and curb the socialistic tendencies in government if the medical profession as individuals and others will put forth the effort now to raise the hard cash to help in efforts of political action.

After considerable discussion, it was decided that Dr. Kernodle should be appointed to make a presentation to the House of Delegates concerning the action of including AMPAC and MEDPAC in the billing.

In the light of the previous action the Council voted to deny the request for a \$2500 educational fund as had been presented in September, and to refer this matter to AMPAC.

The Society of Obstetrics and Gynecology having filed an objection to the adoption of a Relative Value Schedule, the Council voted to invite Dr. Hunter Jones to appear at the afternoon session to make a presentation.

On motion by Dr. Raper, seconded by Dr. Summerlin, the Committee for a Central Headquarters Building was reactivated to study the situation. Dr. Paschal cited a resolution by the Wake County Medical Society asking that this be done.

In a discussion of possible Budget Reduction, Dr. Raiford pointed out that the committees and commissioners set their own budgets, and that an outside study firm would be unqualified to rule on whether the efforts were worthwhile; that a study could only concern itself with the mechanics of spending. The idea of a possible study to see if the budget had any "soft spots" was referred on motion by Dr. Glasson to the Finance Committee.

Relative to the two-year medical schools being proposed in the General Assembly, the Council voted not to take any action whatever, since it was felt that no real unanimity could be achieved, and that any recommendation to continue the work of the Medical Center Study Commission could be interpreted as an action opposing the establishment of such medical schools at Greenville and Charlotte.

Councilors' comments indicated that the Medical Center Study Commission should have a broader geographical base if it were continued, particularly including the eastern part of the state.

On motion by Dr. Beddingfield, seconded by Dr. Williams the Council is to receive the report of the Ad Hoc Committee for Two-Year Medical Schools

and it to be accepted as information only, with no further action by the Society or Council, the motion carried.

Dr. Raiford suggested that the "Executive Committee" be authorized to act in a supervisory capacity on committee function and structure.

Dr. Paschal noted the amount of time that had been saved by the informal "Executive Committee," and asked that it be continued on a trial basis for a year.

Dr. Benton requested that if this committee were to function, then all Councilors should receive an advance agenda, so that they might be present if they were interested, and that a report of all actions be circularized to the Councilors.

On motion by Dr. Poteat, seconded by Dr. Welton, that the group be authorized to continue as a consultant group to the President of the Society, the motion carried. Open discussion clarified the position that the committee was not to be considered an "interim Executive Council" to run the business of the Society, but an informal group of consultants for the President.

(The Council recessed for 10 minutes.)

After the recess the following resolution was presented by Mr. Barnes. This resolution had been telephoned in during the previous week by Dr. Amos Johnson after approval by the Sampson County Medical Society.

Whereas, Forces concerned with economic, political, philosophical, social, and scientific change are exerting profound influence on medical services in America; therefore, change is the order of the day and caught up in this change is American medicine, and

Whereas, the American Medical Association must keep abreast of such changes, study their implications, anticipate their predictable effect, and formulate plans for implementation of desirable change if it is to fulfill its obligations to protect and promote the interests of the American people and the medical profession, and

Whereas, implementation of this essential need would indicate the necessity to activitate a group of representative, experienced, and knowledgeable physicians to conduct a continuing intensive study of medicine and medical services, as it is affected by these inevitable changes, and to make suggestions and recommendations to the House of Delegates and to the Board of Trustees of the American Medical Association as to future policy and action, recognizing that the present Board of Trustees is imminently capable of conducting such study itself, but that the time and effort presently contributed by these men to the Association extends "beyond the call of duty," now therefore be it

RESOLVED, That there be established within the American Medical Association a permanent advisory committee on study, policy, and planning, whose duty it is to study economic, philosophical, political, social, and scientific trends of the day at hand as they bear upon public health, medical practice, and medical care, with consideration of the effects which these may have upon the public and upon the medical profession, and to advise the House of Delegates and the Board of Trustees as to projected policies and programs, and be it further

RESOLVED, That this committee be composed of nine members of the American Medical Association to be appointed jointly by the Speaker of the House of Delegates, the Chairman of the Board of Trustees, and the President of the American Medical Association, for terms of three years each, such terms to be staggered, and be it further

RESOLVED, That this committee shall submit a report to the House of Delegates at each regular session and to the Board of Trustees at any regular meeting.

On motion by Dr. Benton, seconded by Dr. Beddingfield, the resolution was approved and referred to the House of Delegates for action.

A resolution from Lenoir-Greene-Jones Counties Medical Society regarding non-participation was not referred because of flaws in wording and also because it was not presented in time for study as required in the By Laws.

On motion by Dr. Benton, seconded by Dr. Rhodes, the context and intent of a resolution from Mecklenburg presented by Dr. Welton was received as a recommendation by the Executive Council. This resolution would direct the headquarters office to publish the Transactions before January first the following year, and to publish and circulate the agenda of the House of Delegates at least two weeks before such meeting. Mr. Barnes was authorized to hire additional help as needed, and councilors took note that it would be difficult to publish the reports to the House on time unless the reports of committees and commissioners came in on time.

Dr. Beddingfield reported on the House--passed Medicare bill now pending in the Senate, and had words of praise for the support of the North Carolina House delegation of Congress in trying to modify this bill to make it acceptable. Dr. Beddingfield warned against counting the votes on the final bill aganst Congressional friends, since the crucial votes had already occurred and the issue was settled for the time being.

Dr. Beddingfield outlined the plans for the Senate struggle as follows:

In developing the overall strategy of the medical profession, which has been left to the leadership of the AMA, and I think quite properly so, it has been decided that we as a State Society will not be asked to give oral testimony before the Senate Finance Committee. We may make a written documentation of opposition.

The campaign of medicine in trying to defeat this bill as a last ditch measure in the Senate will be somewhat different from what it was in the House of Representatives. The rules of these two different bodies are entirely different. Under the rules of the House of Representatives, no amendments were allowed from the floor. In the Senate, an unlimited number of amendments can be offered, and it is very certain that amendments will be offered, both by proponents of the bill and by opponents. Very likely the proponents of the bill will offer amendments to put back into Medicare the services of the captive specialist, the radiologist, the anesthesiologist, the pathologist, and so forth.

There will probably be amendments to delete the compulsory coverage of physicians under Social Security from the overall measure. There will probably be other amendments to change the Medicare concept, perhaps to insert the concept of need that we think is so important.

You all know as well as I do that the prognosis for many of these amendments that would suit our point of view is very dim, because of the overwhelming Democratic majority in the Senate. However, there is some disagreement between Senate proponents and House opponents, and it is possible this may have to go back to a conference committee, and the thing may drag on for a while, and we may win some concessions.

The overall outlook for Medicare is just what you read in the papers, in my own personal judgment

We will not—AMA and this Society—mount any massive letter-writing campaign before the Senate, nor any advertising campaign on television, or newspapers, radio, and so forth. The strategy at this point is in the technical strategy, the wording of the amendments that will be offered on the floor of the Senate. We still have reason to believe that both North Carolina Senators support our point of view.

Dr. Beddingfield, in commenting on the just-passed optometry bill, noted that though the bill passed it changed very little, and that it chiefly illustrated what the well-organized and disciplined optometrist group could do in getting a bill passed when opposed by the physician group in which most members failed to follow through in passing their reasons on to legislators.

He expressed the feeling that the chiropractors would make inroads unless more busy physicians would take the time and effort to state the case.

Dr. Beddingfield also spoke out forcefully in support of pending legislation to subsidize the three-year diploma schools of nursing. The proposed bill would call for a payment to the schools of \$250 per year. With approximately 2000 students, this would amount to a million dollar appropriation for the biennium.

Regarding the Nurse Practice Act, the report was that the bill had been revised to meet the objections of the Medical Society, and consequently would not be opposed.

Senate Bill 341 was introduced to allow voluntary sterilization of the male in the physician's office, instead of requiring hospitalization.

Regarding a possible psychology bill, it seemed uncertain as to whether it would be introduced.

Mr. Nelson reported a general attitude of anger by members of Congress at the resolutions of nonparticipation by various medical groups in anticipation of passage of King-Anderson type legislation. Mr. Nelson felt these resolutions to be premature and ill-considered.

Regarding the Eldercare program, Mr. Nelson stated:

Almost a miracle occurred in 1965. As you will recall, early in the year, we had the introduction of the expression or the name of Elder Care for a proposition which we were offering in terms of legislation on a national basis. Incidentally, the question was raised many times, why wasn't this presented earlier? Let me go back to the record of 1960, and let's not be confused that Senator Kerr and Mr. Mills were the people who came up with the Kerr-Mills idea.

If you will scrutinize the records of the proceedings of the House of Delegates of AMA for the preceding decade, you will find there the enunciation, the basis upon which Kerr-Mills was founded. We did, in fact, propose at that time—again in '64, we proposed most of what we offered in Elder Care to the Committee on Ways and Means to the House of Representatives, and Mr. Mills and the Committee refused to give consideration to it at that point because of some strategy things that were involved.

As your organization, you were not remiss in making an early presentation, but it was fantastic that the name of Elder Care, and more importantly the concepts involved in it, swept this country like wildfire. There has been nothing like this happen on the national legislative scene in my memory of working in this area for some twenty years now, and I don't ever in the history of legislation anywhere think that there has been the kind of thing that took place with this. There was more mail favoring Elder Care, more intelligent mail, not just the use of the name, but mail which described the benefits of Elder Care presented to members of Congress than has ever been on any other piece of of legislation in the country. But because of the massive thing that happened in the election last fall, that was kind of an uphill sort of thing. The 191 votes that were registered for recommittal of HR 6675, the legislative high point, the education bill I think mustered 153-I think we came 38 votes higher than the next highest objection that was raised.

It was rather fantastic that 115 Congressmen stayed in opposition to the main motion, and this far exceeded our estimates, I can assure you, because we have been checking on this quite thoroughly.

Certainly I want to offer recognition to you folks and Dr. Beddingfield's leadership for the State Society, the staff, and the physicians and others who participated in this campaign this year. This was a masterful job, and the holding of all eleven of your Congressmen for the test vote was a most imporant contribution, and particularly Mr. Cooley, because as Chairman of the House Agricultural Committee, and having over a period of six years said that he would follow the leadership of Mr. Mills—this also was an important facet.

Congress has recognized the test vote, and Dr. Beddingfield has talked about this a little bit—they have recognized the test vote, that is, the vote to recommit the bill to the committee with certain changes, as being the important vote, and the one upon which the measure of strength was to be made.

As of now the bill is over in the Senate. The AMA will testify on the 11th of May, and the format of our testimony will be in continuing of overall opposition to HR 6675, and then to take it line by line, paragraph and section by section, and offer arguments in opposition or arguments for changes in the bill.

As Dr. Beddingfield again has said, there will be amendments, Senator Talmadge from Georgia now estimates there may be forty or fifty amendments that may be offered on the Senate floor. The problem that we have strategically and operationally is how many amendments are we going to try to work with, and what chance have we of getting those amendments to catch hope.

One of the things that we are interested in proposing is the deletion of the hospital portion, that is the King-Anderson portion of the bill. The question becomes one of relativism; with 41 sponsors out of a hundred Senators, what chance do we have of trying to get this section of the bill deleted, and how much effort should we put in it? Should we put in an all-out effort on this and lose it, and then wind up here being weakened in some other area in which we would attempt to work?

There will be perhaps a half dozen areas in which we will attempt to make or get amendments passed. One of them, of course, would be the exclusion of physicians under Social Security, and the deletion or the maintenance of the four hospital specialty groups. Another area is that in which the language would be submitted which would make it permissive or make it possible to have physicians charge usual and customary fees. There are other things involved.

Senator Long of Louisiana has now come up with a deductible feature which would change the benefits schedules of the bill, and this is creating quite a little bit of excitement at the present time.

You will be called upon to make contact with each of your Senators, and we are hoping to have a specific listing of requests to make to them asking them for their support, or opposition to certain amendments on a specific basis. We hope to have this information ready for you in a few days.

Regarding non-participation, Dr. Raiford made

this statement setting forth the position of the Society: "We will obey the law of the land and discharge our responsibilities. A major part of this responsibility, however, must now be borne by the public and the Great Society leaders who have promised so much for so little."

DR. BEDDINGFIELD: Mr. President, if I may, I would like Mr. Anderson to comment on one problem, because we probably should have some direction on the problem that we anticipate coming up in the General Assembly. It is very similar to the problem with the optometrists, except it involves a lot closer kinfolks, the dentists.

As I understand it, this relates to operative dental procedures, such things as oral surgery. This is not to do with fillings and extractions, but it does go so far as to involve maxillary facial surgery being done by some dentists, cleft palates, and so forth. Dentists that are trained and undertake to do such procedures wanted to be treated the same as MD's are that perform this type of surgery under Blue Shield and under commercial health insurance policies.

I think this problem has been discussed in the past perhaps by the Committee on Blue Shield, and I don't believe any action has ever been taken by the Committee on Blue Shield, any definitive action. We would like to have some direction from the Council as to what tack we should take with the dentists if this is introduced, and it probably will be.

DR. RHODES: The Committee on Blue Shield some years ago approved a schedule for a dental rider.

MR. ANDERSON: The problem is that the dentists are not satisfied with that rider proposition, and as a matter of fact a very, very few of those riders have been sold, and it is difficult to sell them, when you say any additional premium is to be charged.

They have come down to this, not proposition, but dilemma. Can something be worked out with the Medical Society's help with the two Blue Shield companies? That's up to the Blue Shield companies. That's an insurance problem they are faced with.

If something cannot be worked out, then the dentists say frankly that will be left as the last resort for them to seek legislation to accomplish their purpose at this session, and very soon.

PRESIDENT RAIFORD: Mr. Anderson, I think this matter should be held in abeyance or referred to the Blue Shield Committee until we know a little bit more specifically what is required. I would like to ask Mr. Beeston to speak.

MR. BEESTON: The dental proposal has a long background. There was a joint meeting of the dentists with the Blue Shield Plan, on some areas of disagreement in the scope of services, where general surgery ended, and where oral surgery began, particularly in the realm of cleft palates, hairlips, and salivary glands, and so on.

The compromise, as Mr. Anderson said, was the issuance of an oral surgical rider at an additional premium. That rider has not sold well. So the dentists are not satisfied.

I will say, however, that the dentists are medical as compared to these other practitioners, and that many Blue Shield plans do pay for dental surgery just as they pay for other surgery. They have participating dentists. Since the legislative position might be stronger if we were allied with the dentists some modification may be in order—but if we added all benefits along with surgery, including other things, I don't know whether it could be sold.

If this gets too bad, we might have to fall back on challenging the constitutionality—can the legislature abridge a contract existing between insured and insurer?

PRESIDENT RAIFORD: What do you suggest we do, Dr. Beddingfield?

DR. BEDDINGFIELD: My personal suggestion, Mr. President, would be this: I think that it would be ill advised to actively oppose the dentists in this. I don't believe that we could do ourselves any good. I think we do ourselves some harm. I think this is primarily a legal matter, an insurance matter, and we don't question the competence of oral surgeons to do these procedures; and I believe that as far as opening testimony before a committee of the General Assembly, I think we would be ill advised to take a stand in this, and that would be my recommendation.

PRESIDENT RAIFORD: Any other questions or any comments? If not, the Chair will entertain a motion for the acceptance of Dr. Beddingfield's report, and the remarks of Mr. Nelson.

(Such motion was regularly made by Dr. Ward and seconded by Dr. Welton.)

PRESIDENT RAIFORD: It has been moved and seconded that we accept this report. All in favor please say "aye"; all opposed? Carried.

(The meeting recessed at one o'clock for luncheon.)

SATURDAY AFTERNOON SESSION

May 1, 1965

The meeting reconvened at 2:15 p.m., Dr. Theo-

dore Raiford, President of the Society, presiding. PRESIDENT RAIFORD: According to the action taken this morning in discussing the Relative Value Fee Schedule, we have invited Dr. Hunter Jones to present the opinions and recommendations of his group, and he is here with us now; so I will yield the floor to him, and would welcome then any suggestions you may have to him in helping us

resolve this diffiulty.

**DR. HUNTER JONES: Thank you, Dr. Raiford. I come as a representative of the Obstetrics and Gynecological Society of the State. We met last weekend, and Dr. Eleanor Easley from Durham

is the Chairman of our Committee on Relative

At our last meeting one year ago, Dr. Easley was appointed Chairman of the Committee to Restudy this whole question of Relative Value, and to communicate with the Chairman of the State Society's Relative Value Committee. This was done, as I'm told. Dr. Easley states that she had no reply whatsoever from the Chairman of that Committee. Just what happened, I do not know.

At our meeting last weekend, this was brought to the attention of the Society, and again the concern of the Society was expressed in the Relative Value Schedule as it now stands, namely, and without trying to prolong this—I might sav first of all, as a (specialty) society, we are not committed to this Relative Value Schedule. There are some in our Society who perhaps favor this, although reluctantly. There are many who are opposed to the entire relative value scheme.

I would imagine that is the case in the State Society. If you could get an honest appraisal of the entire membership of those who understand it, you would find some for it, some against it. and many who do not know. And perhaps we have reached a stage where many do not care, because they have given up and said something is going to happen; somebody is going to take over. It doesn't matter what plan you have. I will do the best I can as long as I can. Perhaps that represents the feeling of too many of us in organized medicine, and I am personally convinced that that is true.

Nevertheless, to get to the point, the chief concern of the North Carolina Obstetrics and Gvnecological Society is that under this plan, which is a plan not forced upon us by the Government, nor by the State, but is a plan being offered by our own State Society and endorsed by the State Society, already-true, it cannot be enforced; each doctor has to decide by himself. But it carries great weight. It is already accepted by this Society. The principle is already established. Our chief concern is that this principle does not make any differentiation whatsoever in our specialty, namely obstetrics, because the general man doesn't do much in the way of gynecology, but certainly the obstetrician's fees and the general practitioner's fees are the same.

Your President has reminded me several times in our talk in the last few days that we are not talking about fee. We are talking about conversion factors related to comparable values. Admittedly that is true. But one leads to the other. The conversion factor is ultimately going to be the fee. Our Society thinks that it's wrong for a principle to be established in which men who have taken the time to become trained, who have taken the time to work toward certification by their boards and are certified as specialists—when it comes to the financial value of their services,

there is no differentiation made. We do not believe this principle is right.

Your President has reminded me that this Society cannot take a stand in saying what one group shall receive as compared to another. Well, if the Society cannot, who can? Are you going to wait for the insurance companies to tell us? Are you going to wait for organized labor, or are you going to wait for the Government, finally?

Can we not, as leaders of our specialties, and of the entire organized segment in this Society, in this State, state what we honestly believe?

Now I am aware of the fact that in this room there are many perhaps general practitioners, and what I have to say has no reflection upon them. I believe they would be the first to admit that there should be a differentiation in the financial remuneration paid the obstetrician for his services from the general practitioner. If that isn't true, why be a specialist? Why not everybody be general practitioners? This is perfectly simple logic. We all understand that. This is our concern.

And if this Council cannot reiterate a principle that a laborer is worthy of his hire, if we cannot tell the House of Delegates and organized medicine of this Society that we believe there should be a differentation, then your conversion factor can be so specified that it should be different. We aren't saying what the fees should be; we aren't mentioning fees. But we think that the principle is wrong.

I would secondly, to close this—if this principle is adopted—it has already been adopted but if it isn't changed, if it finally goes on to its ultimate course, which would be adoption by all concerned, then what is there to initiate the desire on the part of individuals to become specialists? Why should we become specialists? There is no reason for a man to take three, four or five years and do a specialist's work. If his services are not going to be recognized as such for his worth as a specialist, why become a specialist?

It's a question we have to think about. I do not believe that this Council, or this State Society, can stand back and say, well, it's been done by other states, and therefore we won't change it. That's the trouble with organized medicine. We have swallowed, hook, line and sinker, and all, something handed to us by other states and from the Government, and there are few of us left—not many—that what we have done and what we are doing is simply going to spur the Federal Government on one of these days to come in and say "You have already done it; you have laid the groundwork. We will simply take over. You have established these principles. We agree to them thoroughly."

I have to speak for myself as an individual. As far as my Society is concerned, some of it is divided, but I can tell you this: Our Society, the Obstetrics and Gynecological Society, has not adopted the principle of relative value. I do not think it will. It

may be forced down our throats, as everything else is done.

The men in this room, this Council is the Council that takes the leadership in initiating programs. The House of Delegates merely endorses that, or argues about it for a while and finally endorses it. The men in this room are the men who initiate the thinking for this Society, and it is upon your shoulders, gentlemen; you either can accept the principle that the specialist is worthy of recognition as a specialist or not. If you do not believe that, then I have wasted my time coming here, and our Society has wasted its time in any appeal.

I thank you very much for your courtesy.

PRESIDENT RAIFORD: Thank you, Dr. Jones. I would appreciate it if you would wait just a few moments for any questions now. Any suggestions anyone would like to make?

DR. SHAFFNER: May I ask Dr. Jones a question?

I see your point, but I don't see why changing your conversion factor to a higher—that each unit is worth more for a specialist than a general practitioner won't solve your problem. I can't see the difference.

DR. JONES: I can't answer the question except in terms of dollars and cents, it certainly is going to make a big difference.

DR. SHAFFNER: Let's get specific. Suppose a laborer is—suppose something is worth 50 units, whatever that unit is. You may say the general practitioner is one who does general work is assigned \$3. per unit. Why can't you assign \$5. per unit?

DR. JONES: You can, but somebody has to pay that, and the man paying it may object to that—the insurance company, the Government finally—and what is to keep him from saying "Your State Society has not said that there should be a differentiation? Therefore we will not make a differentiation."

DR. SHAFFNER: I thought the whole idea of the Relative Value Schedule is to put it on units, so that there could be a difference in fees for the same service, depending on what a man sets as his conversion factor, or what an area has as its conversion factor, or what the going rate is.

DR. JONES: Who is going to decide that?

DR. SHAFFNER: The individual, unless it is a negotiated thing with the Health Department so far as vocational rehabilitation or something like that. You explain to me why that doesn't show the differentiation.

DR. JONES: The only way I can answer that question is to say under Government's Medicare, not the thing up in Congress now — the ODMC program we have had for many years, we have as a specialty, year in and year out, tried to get the Government to make a differentiation between the fee paid the general man and the obstetrician. We have failed.

That's the ultimate test. The Government says no, absolutely no. You cannot argue with the Government.

We think the same rule will be followed by insurance companies, by the State of North Carolina, by any other group, by organized labor, organized industry. They are going to point to the Government's plan. They are going to say "for years you have been taking Medicare. There is no differentiation there. Why should we make a differentiation?"

PRESIDENT RAIFORD: Dr. Rhodes, do you have any comments or questions? I would appreciate your opinion on this since you have lived with it for quite a while.

DR. RHODES: I may be speaking with two hats, one as an individual, and also one as a representative of the Commissioner under whose commission this committee operates.

I would say this: That certainly I believe that everyone here recognizes the differentiation between the specialist and the general man. I think that—I don't believe there is anybody who doesn't. I think the general practitioner does, because he consults the specialist. I don't believe there is a question here of no recognition in the difference between these two categories of people. I think that is true in other areas, as in internal medicine and general practice, for instance, or in obstetrics and general practice.

This relative value committee began its study of this program eight or ten years ago. I cannot exactly date it. It's been studied for a long time. As a matter of fact, we have had in operation in this State a Relative Value Schedule up until a year ago, when it was decided that it should be revised, and the Committee, after a great deal of deliberion, and effort, to get a response from the various groups within the Society, much of it unsuccessful, really, became sort of stymied, and they decided that in order to establish a North Carolina Relative Value Schedule, that that would entail time and expense which wasn't available. And therefore they finally decided, as I understand it, to adopt the California schedule, the Relative Value Schedule as promulgated in California over a period of some years, and it had been revised a number of times.

I believe that the purpose of the Relative Value Schedule was not to set fees, but to establish a scale of relative values for procedures which could be utilized by the individual in establishing his own fee schedule, or be utilized by groups, such as the Section on Obstetrics and Gynecology, to establish its fee schedules. I believe that is the purpose of the Relative Value Schedule.

I believe also that it is subject to revision. I believe this Society would have to maintain a committee which would be responsible for revisions, depending on circumstances. And while I see Dr. Jones' point that an organization might take this as a means of setting fees—I think perhaps there is an objection on that basis. I don't think it was

intended at all, and I don't think it is intended to establish a fee schedule, but simply within different groups a relative value for the procedures which that group does, so that the conversion factor may vary from one group to another, and it already does vary from one group to another.

For instance, on the vocational rehabilitation, there are at least four or five different conversion factors, as presently established by them, for different categories of service. So I think that what it intends to do is not to establish a fee schedule.

PRESIDENT RAIFORD: Any other comments? DR. GLASSON: President Ted, it seems like we should establish that if it is necessary to revise a Relative Value Schedule, this is not for the purpose of revising the fees, but simply revises the relationship between the values of various operative procedures.

And therefore if one thinks that their fees are too high or too low, the change is not accomplished by changing the Relative Value Schedule; it is accomplished by changing the factor involved, the conversion factor, and the acceptance of the Relative Value principle I think is pretty well accepted.

I think whether the conversion factor in any given situation is right is a matter of negotiation between the parties involved, and I think you can say that the members of the Obstetrics and Gynecological Society might fully accept the Relative Value principle, and each one of them charge completely different fees as individuals throughout the whole Society, and still not violate the Relative Value principle.

You could all charge, one of you in one locality could charge \$300, and another one \$100, and you would still be within the Relative Value Schedule so far as any given procedure.

PRESIDENT RAIFORD: Any other comments or questions?

DR. GLASSON: As long as you didn't violate the relationship of the charge that you were making for these various procedures.

PRESIDENT RAIFORD: I would just like to make one other remark in passing and re-emphasize that acceptance for approval of a relative value schedule—and I intentionally leave out fee schedule—neither helps nor hinders the differentiation of value of services by a specialist or a non-specialist. And it is not the intent of this Council to ask the delegates or the Society to do so, unless any particular group requests backing for this. Then I think it is our province and our point, if this Relative Value Schedule is in effect and it is approved—it is our obligation then to back the party who wants support in differentiating of the conversion factors.

Any other comments?

DR. WELTON: There was a time in our Workmen's Compensation Fee Schedule when there were two sets of fees. One depended upon your being Board certified. To my knowledge, this is still true.

Mr. Barnes might know for sure in the Workmen's Compensation Fee Schedule. Is that not set up so that if you are Board certified, you are eligible for a different set of fees for the same procedure?

PRESIDENT RAIFORD: As a consultant, not as the original primary service.

MR. BARNES: There is a differential in allocation of fees by the Industrial Commission to specialists.

PRESIDENT RAIFORD: On a consultant basis. DR. PASCHAL: Mr. Chairman, I might point out that participation in this is still on a voluntary basis, and it is anticipated by the Committee which has done this work that there will probably be reason to review and revise this Relative Value Schedule in a matter of a few years.

PRESIDENT RAIFORD: I think that is an accepted fact, an analogy I have made previously—this is sort of like a telephone book. It has to be revamped every two or three years because of the increased number of surgical procedures, cardiovascular for instance, which have to be added.

Any other questions? Any other remarks you would like to make, Dr. Jones?

DR. JONES: I would just like to say in closing that what you gentlemen have said sounds good, if you could guarantee it. If you can guarantee that five years from now, ten years from now the specialist in obstetrics, when this conversion factor is converted—what he would get would end up being more, as it should be, than the general man, we wouldn't worry about that.

We understand that relative value from one specialist to another, and there is no argument there. We just don't believe, or are not naive enough to believe that somebody — insurance companies or other groups—isn't going to balk the very first time that we as specialists try to get more than the general man. Why should we? We can come back and say why—because we're specialists. They are going to throw it back and say "Your own State Society doesn't say there should be any differentiation."

I say that a simple statement added to this Relative Value Schedule by this Council, and adopted by the House, that the specialist, when a procedure is done—the same procedure may be done by the general man and the specialist—that the conversion factor for the specialist should be higher than that for the general man—I think that would solve a lot of problems and prevent a lot of grief, especially in the future.

DR. SHAFFER: Can you read what it says on the preface on one of those, the sentence incorporating what he is saying should be included in there?

PRESIDENT RAIFORD: I might read this one statement: It does not state anything about conversion factors, as we have steadfactly insisted. This Relative Value Schedule does not specify conversion factors. But it does state this: "It is equally important to stress that the relative values

or relationships presented in these studies exist only within each of the five sections. Relative values in one section must not be related or compared to those of any other section."

But it does not make any statement about the conversion factor or the unit value.

DR. BEDDINGFIELD: I would like to ask Dr. Jones a question. If such a statement as you propose were to be incorporated in our statement to the House of Delegates, Dr. Jones, how would you define a specialist?

DR. JONES: I think the simplest way would be a man who has board certification or is eligible for board certification, something of that sort. That would be the simplest way that I know.

DR. BEDDINGFIELD: This would not make the specialists who are college members but not board members unhappy, you don't think?

DR. JONES: I don't think it is concerned with whether it makes them happy or unhappy. Speaking for myself, I don't think it enters into it. There are specialty boards set up trying to certify men who are specialists. For hospital staffs, that is what we have to go by; at least we do in my hospital.

That's something else, as to whether a man has to go to college or not.

DR. RAPER: I am against the State Society setting my fees as a specialist as much as you are, but I am practical enough to know that we have to negotiate as a group, and as individuals within the group; and if you accept the philosophy that you have to sit down with anybody to improve your situation, which we have been doing for yearsand the best example of it is in the Workmen's Compensation Act. Our schedule years ago was bad, and through the efforts of this Society in negotiating with the Industrial Commission, they have been raised consistently. Now you either accept the fact that you are going to negotiate or you are not. If you are not, this is good; don't. But the rest of us have accepted the fact that we do have to negotiate with a half dozen or more organizations, Government being one of them.

I like some independence too. I think the time has long gone. So we have to sit down and work. Now we, as radiologists, accept the fact that we will appoint three men, or a half dozen, to work with the State Society to do the best they can for us. This is about as far as we can go. And we accept anything that they come up with with regard to negotiation, Relative Value Schedule or not. And this we turn over to them.

We have lost our freedom. We have lost our ability to be totally independent, and we have to negotiate. If the obstetricians and gynecological men in this State can remain totally independent and not negotiate with anybody, I will take my hat off to you. But I don't think you can, and I think you should accept it not to the extent that you say we are going to accept the conversion factor,

but work for a better one. Work with us and join us, and not try to be independent. If you can be independent, maybe we ought to follow you.

PRESIDENT RAIFORD: Any other comments? If not, I think that will conclude the discussion on this particular item, and we will abide by the Council's recommendations as to the report made to the House of Delegates.

Thank you very much, Dr. Jones, for coming. We are glad to have had the opportunity to hear you.

DR. BEDDINGFIELD: Mr. President, I make a motion that if the Relative Value Schedule is approved by the House of Delegates tomorrow, that the involved agencies be notified and supplied with one copy gratis, and more at a reasonable cost, as determined by the Executive Director.

I would like to add to the motion that all previous schedules disseminated are now obsolete.

(The motion was seconded by Drs. Brinn and Paschal.)

PRESIDENT RAIFORD: It has been moved and seconded that this be done. All in favor say "aye"; all opposed? Motion is carried. We will proceed.

The next item on the agenda, the report of the Committee on Constitution and By-Laws.

Dr. Shaffner, do you have a report on that?

DR. SHAFFNER: Dr. Welton, among others at the February meeting, asked that we write out again the additional proposed changes of the Constitution and By-laws and circularize them, which was sent into the office, and of which I have a copy.

My feeling about these additional Constitutional amendments and By-law amendments is that if the amendments which have to be voted on to remove scientific membership are passed, or are in question at the session tomorrow, perhaps this committee should state the other proposed amendments in case there are objections which come to the floor of the House of Delegates.

There may be some discussion on the floor of the House of Delegates that this will put individual state, component county societies in a position where they are not the judge of their own membership, or are in conflict with the State Constitution.

These new proposed amendments would clarify that, so that they would still be the sole judge of their membership. Therefore, I feel that perhaps these should be available to him at the time when the old amendments as proposed are ratified, in case any discussion would come up about that.

PRESIDENT RAIFORD: Your Committee report then embodies—is actually information, and requires no particular action by the Council at this time.

DR. SHAFFNER: That is correct, if the Council approves of the recommendation for the further changes in By-laws as written in your Council minutes from last February.

PRESIDENT RAIFORD: This was approved, I

believe, last year, in Greensboro. Council recommended, as you will recall, and voted on it, and passed it on a vote of 10 to 5—this is the spelling out of the changes in the Constittuion which would be necessary.

The amendment which you have prepared, is to answer the objections from any county who might feel that their rights are being encroached upon.

DR. SHAFFNER: Correct. That is what we propose to have ready to present. Perhaps during the discussion of the original amendments, if they want it.

PRESIDENT RAIFORD: In other words, this does not have to be acted upon, because it may not be necessary.

DR. SHAFFNER: That's true, except that I think our committee felt it should probably be done anyhow.

PRESIDENT RAIFORD: In that case, would you like action by the Council on accepting this additional amendment?

DR. SHAFFNER: I think the Council should act on it one way or the other, yes. If you are not familiar with it, I can read this additional one.

PRESIDENT RAIFORD: I think it would be well to do it. Most of us have this.

DR. SHAFFNER: The County Society may retain a "scientific membership" if it wishes, and it may, as some have, admit dentists and pharmacists, or other non-physicians to its membership in a classification other than active membership. But only an active physician membership can be active members of a State Society.

If a legally registered physician is other than an active member in a County Society, or if he has been refused membership in it, he may apply directly to the Executive Council for that class of membership in the State Society for which he is available, be it active, interne-resident, student, etc.

These supplemental recommendations for change in the Constitution and By-laws will put those two purposes into effect. And they are to amend Article IV, Section 2 of the Constitution by inserting between the words "the member" the word "active," and the section will then read:

"Active members of this Society shall be the active members of the component societies, and those physicians who are admitted by the Executive Council as hereinafter provided."

That is an amendment to the Constitution which could only be presented and not voted on at this time.

Then we propose an amendment to the By-laws which would add another sentence, and this sentence would be "A county society may admit other members upon such basis or classification as it may determine." So that the entire section would read:

"Each county society shall be the judge of the qualifications of its own members, but, as such societies are the portals to this Society and to the American Medical Association, only reputable and legally registered physicians who are practicing, or who will agree to practice, non-sectarian medicine, shall be admitted as active members. A county society may admit other members upon such basis or classifications as it may determine."

And then finally amend Chapter IV, Section 11 of the By-laws by deleting the present section and inserting a reworded section to read as follows:

The details of the word change I will not give to you now. It is written on this report, if you would like to know it. The reworded section would then read:

"The House of Delegates shall have authority through the Executive Council, by majority vote of the Council, a quorum being present, to elect to membership any reputable and legally registered physician who applies directly to the Society for membership as provided in Article IV of the Constitution, when such physician has been definitely refused admission to a local society and he has appealed to the Executive Council for membership and where, after hearing, the Council is convinced that such physician is eligible for membership in the State Society and that it is impossible to reconcile the local society to admitting him. The Executive Council shall certify the election of such physician to the Secretary. A member so elected shall, on payment of annual dues and assessments for the current year, be entitled to the rights and privileges of membership as provided by Article IV of the Constitution."

PRESIDENT RAIFORD: Do I hear a motion of approval of this report?

(A motion was made by Dr. Reece and seconded by Dr. Bridger.)

PRESIDENT RAIFORD: Any discussion? If not, all in favor say "aye"; those opposed? Motion carried

I think it might be well to present this, Dr. Welton, and see what the Council's reaction is to it. It cannot be enacted this time, but it could be referred to the Executive Committee.

DR. WELTON: Mr. President, there has been some discussion a number of years, and I think at one of our previous meetings this came up, and that is to stagger the terms of the Councilors, rather than electing ten all at the same time every three years, as has been done for a number of years, and with the intention of getting an expression of opinion, and some possibility of action on this, I should like to propose that you consider this, and that in 1967, for example, after ten new Councilors have been elected, they be instructed to draw lots, and four of them would get a one-year term, and three a two-year term, and the remaining three a three-year term.

In 1968, the one-year term men would be replaced by Councilors elected for three years, and the following year three more. Thus we would have new men coming into the Council, a few each year, rather than ten all at once. There are obviously other ways to accomplish this same purpose such as the division of five and five, and I believe perhaps the proper procedure is to ask the Council to refer this matter to the Committee on Amendments—Constitution and By-laws—and ask them to draw up the proposal which would specify the mechanics of this, and report to us at our next meeting.

PRESIDENT RAIFORD: The Chair will entertain a motion to the effect that this matter be referred or recommended to the Committee on Constitution and By-laws. Do you wish to make such a motion, Dr. Welton?

(Such motion was made by Dr. Welton and seconded by Dr. Ward.)

PRESIDENT RAIFORD: It has been moved and seconded that this matter be referred to the Committee on Constitution and By-laws. Is there any discussion? The purpose of this simply is to prevent the contingency of having ten new Councilors sitting in at the same time.

DR. BRINN: How often has it occurred that we had ten new members at one particular time?

MR. BARNES: I don't believe it has ever actually happened; not in the 18 years I have been with the Society. It could happen.

DR. WILLIAMS: Hasn't the Nominating Committee in its wisdom and foresight prevented this from happening in the past and pretty well taken care of this to more or less of a degree?

PRESIDENT RAIFORD: It has, I believe. However, it is conceivable too that you might have ten new members of the Nominating Committee at one time. This is a safeguard.

You have heard the question. All those in favor please say "aye"; all those opposed? Motion is carried.

Now the report of the Treasurer, Mr. Barnes.

MR. BARNES: I think that this audit report was discussed by the members of the Finance Committee at the February meeting, but I might just touch on it here.

The allocations in the budget of last year amounted to \$250,908, was actually collected to the extent of \$247,384.31, leaving a difference of \$3,526.69, under your budget estimates of revenue for the year.

For the year, we had authorized expenditures of \$228,732.38, showing a profit of \$20,558.81 in the operation for the year. That does include a sum of \$1,837.88 for equipment which was expended, but which is calculated in the profits for the year, inasmuch as the value of that carries over into the next year.

Now coming down to the present year's operation, as of March 31st, you adopted a budget of estimated income of \$284,345 for 1965, and as of March 31st, actual collections of that \$209,406.88.

You authorized an expenditure budget of \$255,-

265, and as of March 1st, there had been an expenditure of \$50,470.79, or an excess of income over expenditures for the first three months of this year of \$156,999.09.

I would simply comment that that is a fairly favorable picture both for last year and for this year. I think if you will study the audit report, you will find most of the expenditure budgets were underspent, and we did our best in management last year to make it so. The Finance Committee, as I recall, were satisfied with this report of the Treasurer.

Now our reserve funds, we have a total investment as of January 1, 1965, of \$133,173.65, which of course represents roughly a cash investment of \$103,000 plus; increments of dividends over the years have brought it to that level. But the investment of this \$133,000, according to asset values at January 1, 1965, was \$153,508.26.

I can say that according to the latest information from Investors' Mutual, the asset value has now exceeded \$12.60, which is the highest it has ever reached. And I suppose this figure, if calculated today, Dr. Benton, would probably be in the neighborhood of 155 or 156 thousand dollars, rather than \$153,000, because I think this was based on \$12.39, or something like that, January 1st.

Unless somebody has some questions, that's the report.

PRESIDENT RAIFORD: You have heard the report of the Treasurer. Any questions? If not, do I hear a motion for the acceptance of the Treasurer's report?

(The motion was made by Dr. Ward and seconded by Dr. Williams.)

PRESIDENT RAIFORD: It has been moved and seconded that the Treasurer's report be accepted. All in favor please say "aye"; opposed? Carried.

DR. BEDDINGFIELD: At the last meeting of the Council, Council considered a report from the subcommittee of the Mental Health Committee. This subcommittee pertained to the Mental Health Services for children. This was sent out in advance of the last Council meeting and when it came time to vote on it, there were several things in there that raised some questions as to whether this should be adopted as official State Medical Society policy.

Dr. Thompson, Dr. McCain, and I have been over this thing in rather meticulous detail and we have made some changes, and I believe the revised report has been distributed.

There were one or two other changes suggested in our discussion that still crept through in our revised report and I would like to mention those very briefly.

I would also point out that a Committee on Child Health of the Society has met subsequent to the last Council meeting, also adopted an official committee position questioning some aspects of the report.

We talked to Dr. Scurletis interested in School

Health from the State Board of Health, and to some other people, and their suggestions are incorporated into this revision. (See Report of Committee on Child Health.)

DR. D. A. McLAURIN: The School Health Committee, at a meeting since the previous Executive Council meeting, has taken exception to the approval of this pending a detailed review by several of the State Society's committees.

I would hope, as Chairman of School Health, that the Council will see fit to consider further this document at such time as the revisions have been inserted, and refer this to the appropriate committee.

There are a number of things—I see no point in detailing them to consume your time here. I would be most appreciative, as a committee chairman, that my committee have the opportunity to go over this once these revisions are inserted before final action is taken.

PRESIDENT RAIFORD: You have heard Dr. McLaurin's statement. Does any Council member wish to make a motion that this be further cleared with the Committee on School Health?

DR. WILLIAMS: I would make such a motion. (The motion was seconded by Dr. Murphy.)

PRESIDENT RAIFORD: Any discussion? All in favor of the motion then say "aye"; all opposed? Motion is carried.

On motion by Dr. Glasson, seconded by Dr. Bridger, the report on Ambulance Study was accepted.

DR. McLAURIN: The thing that I am most concerned about is that we consider very carefully the Utilization Committee as you have proposed.

The law, as I understand it, very definitely does require that utilization or review committees be established. I think it behooves us as practicing physicians to be absolutely certain that we have very soundly based utilization committees functioning. This is a problem of the practicing physician, and it is essential that we as practitioners handle this ourselves.

The thing that I am most fearful of is that the type of review committee that is established in England, to which a physician has to answer to non-medical people, might become a reality here. Although lip service and some wording in the law was given to providing our being certain that there will be no interference with the practice of the private physician, I am still very concerned about this.

PRESIDENT RAIFORD: Thank you, Dr. Mc-Laurin.

I would like to comment very briefly on this. You will recall in September 1964 the Council authorized me to approve a Utilization Committee, and during the next three months, I conferred and discussed this matter with representatives from other states, and especially during our meeting of the Organization of State Presidents in Miami, as to

how it was done there. The construction of this committee, as outlined in the February meeting, seemed to be the coordination of the better points that had been worked out in the different states.

Now this committee, as you will recall, is composed of representation from each party involved. The Medical Committee is composed of nine members representing each of the three committees that we have who are interested in this problem, Blue Shield, Hospital and Professional Relations, and Liaison with the Insurance Industry, plus three at large. That's a liaison committee, and the intent behind making this a liaison committee was that it and this committee, and the committee representing the Hospital Association, for instance, or the Health Insurance Council, were not at cross purposes.

Is there any feeling that this committee should be altered or dissolved, and a new committee appointed?

Dr. McLaurin, have I expressed my feelings clearly on that? I mean the purpose of the three-part committee.

DR. McLAURIN: Yes. The thing that disturbs me, Dr. Raiford, is the statement of function of this committee.

"Shall be to represent the Medical Society in a liaison and advisory capacity to similar committees representing the North Carolina Hospital Association, the North Carolina State Committee of Health Insurance Council, and representatives of state agencies whom the Governor might see fit to designate, including the Insurance Commissioner of the State of North Carolina, in stating the problem of overutilization of health insurance and policies, to prevent abuse in this area."

It seems to me that we are acknowledging that these people have a vested interest to come into and investigate what the physician is doing. Now they have got a monetary interest, because they're paying the bills; but it seems to me that as physicians we should reserve for ourselves this business, and we will meet with them and discuss the problem. This is the thing that disturbs me.

PRESIDENT RAIFORD: That was the sole intent of this, that our Utilization Committee would meet with them and discuss it.

Now if there is any misinterpretation of function there, or statement of function, why I would be perfectly willing to accept any suggested alterations. What is the will of the Council?

DR. RAPER: Dr. Raiford, I would rather negotiate on a state level than on a county level or hospital level; and as long as we keep it up—I mean you've got to negotiate sometime, somewhere; otherwise you don't even need a utilization committee. The only need that we have—we're pushed into this, and we're trying to do it ahead of schedule. Many of the other states have been absolutely forced into it by court order, and what we're trying to do is get ahead of the game and go

ahead and set it up voluntarily, and the wherewithal to negotiate, if we have to negotiate. And I would rather see it on a state level than some other level; and you might as well get the machinery going for what is going to happen eventually anyhow.

If our present bill is even close to what is about to pass now, Medicare, each hospital has to set up a utilization committee anyhow, so it's going to be done for us whether we want to or not.

I am all in favor of taking the bull by the horns, get going on the thing, instead of somebody else telling us what we've got to do. And if we can get it started now—and I don't mean next year, but I mean now—get something going on this thing, we're ahead of the game.

PRESIDENT RAIFORD: I would like to point out two things. I have talked with George Stockbridge and Ed Abbott, representing the Hospital Association and Health Insurance Council, and they have been most cooperative in this thing; and I would also like to point out that we selected the nine members very carefully, and I could say that our medical committee is a little bit larger in size than any other single committee, so I don't think we're going to have too much trouble on this.

We had hoped to have a meeting of the chairmen of the respective segments before now, but in view of the present legislation, it seemed feasible to wait until that was more or less settled—because that may alter the concept of utilization considerably.

I think this requires no definite action, and I am glad Dr. McLaurin was here to bring this up, because some of the things we heard at this National Social Welfare Assembly were rather disturbing, and I think it's all the more reason why, as Dr. Raper said, we should get started on this thing before we're started upon.

Dr. Beddingfield, do you have anything to report on nursing homes?

DR. BEDDINGFIELD: Yes. A few weeks ago, I had the privilege of appearing on the program at the North Carolina Association of Nursing Homes, and appearing on the same program was a representative from the Veterans Administration, who described to the nursing home group a new program that is being implemented as of July 1st here in North Carolina by the Veterans Administration to provide nursing home benefits for non-service connected disabilities in licensed nursing homes here in North Carolina.

It appears to me that the intent of the program is to get people out of the Veterans Administration hospitals, non-service connected disabilities, so that they can get some more non-service connected disabilities in, and this makes it look better, because you don't have to build new beds.

In implementing this program, they have their own criteria for the type of nursing homes that they will pay. They have a fixed fee schedule, regulations regarding the frequency of visits to physicians in the nursing homes, requirements regarding the proximity of x-ray and laboratory facilities, requirements regarding non-discrimination. They envision a social worker service, so that a social worker from the Veterans Administration regional office in Winston-Salem will visit patients in these nursing homes across North Carolina.

I was not aware that this had been authorized by the Congress, but we talked to Mr. Nelson about it, and we found out it had, through some form of legislation that slipped by us. I merely pass this along as information, and the Committee on Legislation is trying to get a little more information about it right now.

Several physicians across the State have had the experience in the past month or so that veterans they were treating under the home town care program, who had been having their prescriptions filled in the local community pharmacy — the patients had been directed to secure the prescriptions from physicians and mail them in to Winston-Salem, and it was filled there and sent directly, eliminating the local pharmacy.

At times the physician has been directed to write such prescriptions on a Veterans Administration prescription blank. The question has come up of generic versus ethical brand name drugs. Although in fairness we must say that if a physician checks the proper box, he can specify the generic equivalents not to be used.

Another development in this prescription program came to the attention of Dr. Dees' committee. Dr. John Dees is chairman of a Committee on Liaison to the North Carolina Pharmaceutical Association, and he has asked me to report on it, because he couldn't be here today.

This is a new program that the Veterans Administration has that was implemented here in North Carolina on April 1st, which provides prescription service for non-service connected disabilities for veterans who are receiving a pension. This is under the provisions of Public Law 88-664, and under regulations drawn up by the Veterans Administration implementing this new public law. It says this:

Veterans of World War I, World War II and the Korean Conflict who are receiving increased pensions under Section 521 D of Title 38 U.S. Code, based on need of regular aid and attendance may be furnished drugs and medicines on prescription of a duly licensed physician as specific therapy in the treatment of illnesses or injuries suffered by such veterans. Necessary drugs and medicines under this subparagraph will be provided by VA pharmacies on prescription of a doctor of medicine or osteopathy who is licensed to practice his profession and to prescribe drugs and medicines in a State, Territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico. In the State of Alaska, the Territories

or possessions where there are no VA pharmacies, necessary drugs and medicines may be furnished on a reimbursement basis.

This came to Dr. Dees' personal attention when he had a patient he had been treating for sometime, and the patient walked in with VA prescription blanks and a letter instructing Dr. Dees to write a prescription and mail them to Winston-Salem, and the patient would presumably be getting the medicine back.

There is a question in the mind of the Committee on Liaison to Pharmacy as to whether this was actually authorized in the Public Law to which I have referred, or whether this is a Veterans Administration interpretation based on the regulations they have drawn up.

No action is required, except the approval of this Council for the Committee on Liaison to Pharmaceutical Association to pursue this further with an analysis of the implications to Federal legislation, and perhaps some communication with the Congressional delegation.

DR. RHODES: Mr. President, I am interested in this because I was sort of astounded a few days ago when a retired colonel, whom I have known for ten years and have seen him at intervals, usually, if I prescribed any medicine, I call the local pharmacist, and he sends it out to this gentleman, when he said to me, "You write me a prescription, and I will sent it up yonder; I can get it a lot cheaper," I said "What do you mean?" He said "I'll send it to Washington, and I can get my drugs a lot cheaper in Washington."

DR. BEDDINGFIELD: I think the retired colonel getting it in Washington was a different deal. This is an association of retired officers that have their own mail order prescription drug plan. This is a mail order prescription plan, I think that he was involved in, but this is a new one that the VA has operating in North Carolina. It is for nonservice connected disabilities.

PRESIDENT RAIFORD: Do you have any actions or requests, Dr. Beddingfield?

MR. BARNES: There is some suggestion that the Society should consider reactivating this Committee for Veterans Affairs.

PRESIDENT RAIFORD: What is the will of the Council?

The Chair would entertain a motion to the effect that this be further considered by the Committee on Legislation, and the Committee Liaison to the Pharmacy Industry, with consideration of reactivation of the Committee on Veterans Affairs, if the need arises.

DR. WILLIAMS: I so move.

(The motion was seconded by Dr. Bridger.)

PRESIDENT RAIFORD: Dr. Williams has so moved, and it has been seconded.

DR. KERNODLE: I just arise to remind the Council that Samuel Elfmon was Chairman of the Veterans Administration Committee five years ago,

or about that time; he felt that there was no further need for his committee to function. We asked him to maintain his status because of things coming up.

For another year he maintained his status with the committee—so again nothing; so it was dissolved spontaneously. But this measure—I happen to be on the Drug Committee, and I am familiar with what Dr. Beddingfield has said — is only one of several now coming up, and we have got the other one on the nursing home problem, and two or three others. I think that the Council should cake a strong action by reactivating the Veterans Affairs Committee rather than just taking the silent way that if the occasion arises, the need for that committee — I think there is a need for it to be reactivated.

PRESIDENT RAIFORD: Any further discussion? I would interpret this motion as stated by Dr. Williams and seconded by Dr. Bridger to authorize the President to reactivate Dr. Elfmon's committee at any time he saw fit.

No further discussion? All those in favor please say "aye"; all opposed? The motion is passed.

The mosquito report. Mr. Barnes, do you have any further additions on this?

MR. BARNES: This conference in Atlanta on the 4th and 5th of March with reference to the Aedes Aegypti mosquito was attended by Dr. Marion Pate of Robeson County, Mr. Don Ashton of the North Carolina State Board of Health, and myself.

I believe the gist of it is that they have a real problem of the presence of this mosquito, which is responsible for conveying the yellow fever disease, and that there is potential of reinfecting Central and South American countries from North American sources.

However, we found in the conference in Atlanta that apparently North Carolina is not involved, so this report which had been prepared by Mr. Don Ashton does represent what transpired in Atlanta, and we would like for it to be accepted for the record and published in the record of the transactions.

Report of Investigation or Inspection of Aedes Aegypti Eradication Conference

A conference, sponsored by the American Medical Association and the U.S. Department of Health, Education, and Welfare - Communicable Disease Center regarding Aedes aegpti (the Yellow Fever Mosquito) eradication in the United States was held at the CDC headquarters, Atlanta, Georgia, on March 4-5, 1965.

D. F. Ashton, Entomologist, N. C. State Board of Health, represented the State Board of Health; Mr. James T. Barnes, Medical Society of North Carolina, and Dr. M. B. Pate, Lumberton, repre-

sented the Medical Society of North Carolina at this meeting.

EVENTS LEADING TO THE CONFERENCE:

The eradication program is part of an international effort to eradicate the Yellow Fever Mosquito, Aedes aegypti, from the Western Hemisphere. In 1947, at a meeting of the Directing Council of the Pan American Health Organization, and again at its meeting in 1961, a resolution concurring in the desirability of a hemisphere-wide eradication program was signed by member nations, including the United States. During the ntervening period, Aedes aegypti populations have been cleared from the major portion of the area outside of the United States. Now these other nations have pointed out that Aedes aegypti in the United States might be a possible source of accidental reinfestation of their countries. Recognizing the validity of their fears and responsibility of the United States to support the hemispheric effort, as well as the possible hazard to the United States, in 1962 Surgeon General Luther L. Terry committed this country to join in the eradication effort. In 1963, Congress gave substance to this commitment by appropriating three million dollars to finance it during fiscal year 1964.

Indicative of the concern of private medicine in this potential health threat is the following quote from a report approved in December, 1964, by the House of Delegates of the American Medical Association:

"The Board believes that the American Medical Association should cooperate with the Communicable Disease Center of the Public Health Service in promoting eradication of Aedes aegypti mosquitoes, and recommends that House of Delegates encourage the state and local medical societies of the States and territories concerned, and the physicians practicing therein, to coperate in every possible way to insure complete eradication of Aedes aegypti mosquitoes from the American hemisphere."

EXTENT OF PROBLEM:

During the summer of 1964, the Public Health Service, in coperation with state and local health departments, conducted an extensive survey in an eleven state area in the southern United States. Results of the survey showed that there were infestations of Aedes aegypti in 566 communities in 203 counties or parishes in 10 states - Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. Infestations appear to be centered in Alabama. There is a solid block of counties in southern Alabama and neighboring areas of Georgia, Florida, and Mississippi, that have generalized infestations, that is, in small towns and rural sections, as well as in central cities. This is surrounded by an area where the infestation is scattered and usually limited to the central city. Tihs area includes most or all of the states of Florida, Georgia, South Carolina, and the eastern part of Texas. In Arkansas, Louisiana, North Carolina, and Tennessee, known infestations are limited to one or two counties.

While the 1964 survey for Aedes aegypti was extensive in nature, it represents a very small sample of the premises that could be infested. Further inspections will undoubtedly find additional areas of infestations.

THE MOSQUITO - AEDES AEGYPTI:

Aedcs aegypti is a domestic mosquito. It develops exclusively in artificial water-holding containers in close proximity to human habitations in both urban and rural areas. Discarded automobile tires, paint buckets, jars, tin cans, and flower pots containing water are preferred breeding sites. In these receptacles the eggs may survive adverse weather conditions and remain viable for one year or more. Junk yards, municipal dumps, and refuse dumped indiscriminately elsewhere, all present special problems in eradication.

POTENTIAL HEALTH THREAT:

The Yellow Fever Mosquito, Aedes aegypti, is responsible for transmission of two virus diseases - yellow fever, which produced a very high death rate in nonendemic areas, and dengue, which seldom kills but may cause severe illness and prolonged debility.

There have been no outbreaks of yellow fever in this country since 1905. The last reported death from yellow fever in the United States was an immigrant from Mexico at Houston, Texas, in 1924. Since that date there is no record of a case originating in the United States. However, extensive outbreaks of dengue occurred throughout the first half of the century. There was an epidemic in the Caribbean area in 1963-64, with more than 30,000 cases reported. A number of people came to the United States from the Caribbean during this period and later developed clinical cases of dengue but there was no epidemic in this country. With the virus of both diseases present in the hemisphere, today's rapid transportation could easily allow either or both diseases to become reseeded among Aedes aegypti populations in this country.

It is well established that Aedes aegypti is abundant in both Puerto Rico and the Virgin Islands, and that dengue was prevalent during the 1963-64 Caribbean epidemic.

THE 1964 OPERATIONAL PROGRAM:

Operations were started in 1964, in Florida, Texas, Puerto Rico, and the Virgin Islands. These states and territories were selected because of the large numbers of yellow fever mosquitoes found here and because large international airports are located in both Florida and Texas, the proximity of Texas to the reportedly Aedes aegypti free nation of Mexico, and, because dengue was prevalent

in both Puerto Rico and the Virgin Islands. As funds become available, the work will be initiated in Alabama, Arkansas, Louisiana, Mississippi, North Carolina, South Carolina, and Tennessee.

A cooperative State-Federal program to eradicate Aedes aegypti is being conducted through contractural arrangements with state health departments. Under the terms of the contracts, the Public Health Service assigns Federal personnel to state health departments as needed to provide technical direction to program activities in accordance with state policies.

Cooperating states assign a state director, a permanent employee of the state health department, for general administrative and policy supervision of the over-all program. Under the state headquarters, the organization is decentralized into operating areas usually encompassing one or more counties. Each area is headed by an area supervisor, a federal employee in charge of a force of foremen, inspectors and spraymen. These workmen are state employees but are paid from Federal funds furnished under the contract.

Additional contract responsibilities of the Public Health Service include furnishing supplies and equipment, training, research and development, and planning.

Although the program stresses elimination of mosquito breeding places by improving premises and community sanitation, this must be accompanied by insecticidal operations in order to achieve eradication. The standard methods consist of premises by premises search for Aedes aegypti breeding containers and treatment of infestations with 1.25 per cent DDT emulsion.

RECOMMENDATIONS:

It was felt by members of the CDC Aedes aegypti eradication program, by state health department representatives, and by members of the American Medical Society who attended this meeting that the doctors of health departments in the various infested states should become well informed regarding the aims of this program. It was suggested, however, that no great amount of publicity be given out to the general public until work is to be started in the state. It was also emphasized that all effort should be made to prevent any "scare" publicity. It is essential that the doctors as well as the general public should be well informed. CDC and AMA representatives felt that the doctors should assume the responsibility of the dissemination of accurate information and that of encouraging their patients to cooperate in the program.

It will probably be several years before eradication work is started in North Carolina.

PRESIDENT RAIFORD: Is there a motion to accept this report?

(Such motion was moved by Dr. Ward and seconded by Dr. Paschal.)

PRESIDENT RAIFORD: It has been moved and seconded that this report be accepted for inclusion in the transactions. All in favor please say "aye"; all opposed? Carried.

Next, the Attorney General's chiropractic opinion, Mr. Anderson.

MR. ANDERSON: As a result of the chiropractors' displeasure with the Industrial Commission's refusal to pay for urinalysis made by them, and some other discussions, the Chiropractic Association requested the Attorney General to give them a ruling on several questions, the first of which was whether or not a chiropractor could lawfully make a urinalysis.

The answer to that was that there is nothing in the law to prevent a chiropractor from making a urianalysis for his own information, but he couldn't make a diagnosis and impart it to the patient as to the results of that test.

On the other question they asked, as to whether or not a chiropractor could take a blood sample and make blood tests, microscopic examinations of blood, the Attorney General ruled that the puncture of the skin being a surgical or medical procedure, it would be unlawful for the chiropractor to perform such a procedure.

He left in the air the question of whether he could make a microscopic examination of blood if it just got out of the patient by some other means.

PRESIDENT RAIFORD: Thank you, John, for a very concise report. The Chair will entertain a motion for acceptance of Mr. Anderson's report as information.

(Such motion was made by Dr. Paschal and seconded by Dr. Beddingfield.)

PRESIDENT RAIFORD: All in favor please say "aye"; opposed "no." Carried.

We come next to the report of Councilors. Dr. Brinn.

DR. BRINN: No further report. I would like to take note at this time that Dr. Z. D. Owens, Past President and for a long time Councilor of the Medical Society of North Carolina, was recently involved in an automobile accident resulting in fractured ribs and confinement to the hospital. I think that some expression of the Executive Council of the Medical Society should be sent to Dr. Owens. It would be appreciated.

PRESIDENT RAIFORD: Thank you, Dr. Brinn. The Chair will entertain a motion that a suitable communication be sent to Dr. Owens expressing our regret at his accident, and our hopes for an early recovery.

(Such motion was made by Dr. Paschal and seconded by Dr. Rhodes.)

PRESIDENT RAIFORD: Such communication will be sent by the Secretary, if you approve.

(The other nine Councilors had no further report.)

The only addition to Commissioners report was the following by Dr. Mark Lindsey for Professional Service Commission:

DR. MARK LINDSEY: The committees have all met this year in the usual fashion, with one very striking exception which you have heard about already. This is the Committee on Nursing, and I rise at the risk of being reiterative to urge the Council individually and collectively to be aware of, be familier with, and to support what has already been mentioned, H.B. 305.

This, as Dr. Beddingfield said, in an appropriation request for some one million dollars for the diploma students in North Carolina. Dr. Beddingfield did not mention that he and Mr. Barnes got out a very fine letter to 2200 physicians in the counties which did have diploma schools, and if you have not seen this, it gives succinctly the reasons for physicians supporting this bill.

On motion by Dr. Beddingfield, seconded by Dr. Bridger, Commissioner reports were accepted.

Dr. Ward was recognized for an addition to report.

DR. WARD: The State Board of Health Cancer Control Program for North Carolina — most of you are familiar with the provisions of such, and what it does.

The Cancer Committee of your Society has worked with the State Board of Health very closely through the years in this Cancer Control Program. This is for diagnosis and treatment of indigent cancer patients in the State of North Carolina. It is a hospital and a doctor program, as you know.

Each year this program receives an appropriation from the legislature which runs out in about eight months. It ran out this year in eight months. Dr. D. F. Milam, recently deceased, talked with me only a week before his death concerning this matter, and it was his hope that we could get an additional appropriation this year to run us through the twelve-month period.

We did not get such an appropriation. In the past, the Governor has seen fit at times to give us additional monies from contingency funds of the State to continue this program for twelve months. We did not get the additional appropriation this month, and the Cancer Control Program stopped at the end of eight months.

It was the recommendation of the Committee on Cancer to the Executive Council on two previous occasions that this Council go on record as approving an additional amount of \$100,000 to the State Board of Health Cancer Control Program, in order to run this program for a full twelve months. This was Dr. Milam's figure that he presented to me to be brought through the Cancer Committee to the Council, and at this time I would like to make a motion that this Council go on record asking the State of North Carolina for an additional appropriation of \$100,000 for the State Board of Health Cancer Control Program, in order that this

program can be run for a twelve-month period, and that this be sent to the Joint Appropriation Committee.

I have talked with Dr. Norton about this, and Dr. Milam.

I would like the Council to pass a motion to be sent to the Joint Appropriation Committee requesting an additional appropriation of \$100,000 per year for the State Board of Health Cancer Control Program of North Carolina in order that this program might run for a full twelve months, realizing that now existing funds being appropriated only run the program for eight months.

(Dr. Beddingfield seconded the motion.)

PRESIDENT RAIFORD: It has been moved and seconded. Is this motion clear?

DR. BEDDINGFIELD: It would have to go to the subcommittee, because the Joint Appropriation Committee is already dissolved — Subcommittee on Appropriations.

PRESIDENT RAIFORD: That that be transmitted from the Executive Council to the Subcommittee on Appropriations.

You have heard the motion. Any further discussion?

DR. RHODES: Does this affect the cancer hospital down in Lumberton? Do they get any funds through this?

DR. WARD: No. This is State Board of Health Control Program, and is administered by Dr. Milam's Department, but of course Dr. Milam — Dr. Norton says they don't have a succeeding head yet, but they will. It will still come under the State Board of Health.

DR. BENTON: Mr. President, can I ask a question? Does that have to do with the Pap smears?

DR. WARD: Yes, sir.

DR. BENTON: I have a complaint to register from a pathologist in Greensboro. They say that Dr. Norton is not limiting it to the indigent and near-indigent, but has taken all the Pap smears coming and going; and if they would limit it to the indigent and near-indigent, you wouldn't need the other money. They're sending rich and poor alike, and they're fussing about it.

DR. NORTON: We don't make any inspection. We take the recommendtaion of the physician.

DR. BENTON: Then you're not limiting it to the poor and indigent.

DR. WARD: This has been brought up in the Committee on Cancer. This is a real problem. and Dr. Milam has brought this to our attention several times, and he doesn't have any way when that request goes in to tell whether a case is indigent or private.

Now this is not a controlled project of the State Board of Health. This is a physician controlled project and should be controlled through this Society through its physicians, because he cannot tell whether indigent or private, and the physicians of the State are sending their private Pap smears to the State Board of Health to be read, and this figure is about 80 per cent, and this is not right.

Now the Cancer Committee has discussed this several times and has tried to do something and probably should do more, and I think we will need to do more the coming year to get this figure of the private Pap smears from the physicians cut down to where the State Board of Health is doing the indigent Pap smears, and I think that pathologists have a legitimate gripe in this. I think, as I say, the Cancer Committee will try to do more in controlling this.

PRESIDENT RAIFORD: Any further discussion? All those in favor of the motion please say "aye"; all opposed "no." The motion is carried.

Now the committee reports, all of which are included in the Compilation which you have in your green folder.

I would make a comment here in that meeting with the Advisory Board, Medical Advisory Board to the Department of Vocational Rehabilitation two weeks ago, we requested that the Committee or a subcommittee of the Committee on Physical Rehabilitation be authorized to act as a Liaison Committee with the Department of Vocational Rehabilitation. This was accepted by the Department, and I think will give us a better liaison capacity than we have had in the past.

PRESIDENT RAIFORD: The Chair will entertain a motion for acceptance of the committee reports as included in the Compilation.

(Such motion was made by Dr. Glasson and seconded by Dr. Benton.)

All in favor of accepting the Committee reports together with the supplementary information please say "aye"; all opposed? Motion is carried.

PRESIDENT RAIFORD: The American Medical Association "Judicial Council believes that its Annual Disciplinary Report needs to be more complete and should take into account all actions by county medical societies and, possibly, hospital medical staffs, as well as actions taken by state societies and licensing boards. It is hoped that state medical societies will improve mechanisms for keeping abreast of disciplinary steps taken by their county societies so that this information can be forwarded to the AMA."

What is your pleasure? This is a request from the Judicial Council of the AMA that we keep them informed as to actions taken, and the disciplinary actions taken in this state or in any counties.

DR. PASCHAL: If we're going to do this, I think it might be worthwhile considering doing it in code. I would hesitate really to call names in the report to a central collecting agency. And I don't know whether we would do our membership a service by complying to the letter with this request or not.

MR. BARNES: You also collect the information from the county societies in code, Mr. President-elect.

DR. PASCHAL: That would have to be done, too.

MR. BARNES: If you're going to report to the AMA, you have got to have the information from the component societies, and we have no access to it unless you authorize it; and unless you worked out something, as you say, in code, I think there would be a great reluctance to reveal whatever disciplinary actions do take place at the component society level.

PRESIDENT RAIFORD: There is a motion to the effect that the Council approve compliance with the AMA's Judicial Council request in which no means of identification is included? I will entertain a motion to that effect.

(Such motion was made by Dr. Brinn and seconded by Dr. Reece.)

PRESIDENT RAIFORD: Any further discussion? The motion is carried.

Dr. Reece has an announcement, gentlemen.

DR. REECE: I want to make one small an-

nouncement concerning the organization of the House of Delegates tomorrow afternoon. I am going to ask the Commissioners to serve as the Reference Committee, the six members, and Dr. Benton, will you serve as Chairman of the six? All resolutions that are presented will be given to you.

PRESIDENT RAIFORD: Is there any other business? Well, gentlemen, this is my final tenure of presiding at this Council. I want to take this opportunity to thank you all for being attentive, bearing with me, and helping me expedite the actions of the Council.

I hope we haven't cut somebody's toes off. I think we have managed to get through in time on every occasion so far before five o'clock. I certainly appreciate it, and I want to take this opportunity to thank you, and I hope you support George next year just as well.

Thank you very much.

The meeting is adjourned.

(The meeting adjourned at four-thirty o'clock.)

Minutes of House of Delegates Meetings

SUNDAY AFTERNOON SESSION

May 2, 1965

The First Meeting of the Annual Meeting of The House of Delegates of the Medical Society of the State of North Carolina, held at the Merchandise Mart, Charlotte, North Carolina, convened at 2:15 p.m., Dr. John C. Reece, Speaker of the House, presiding.

PRESIDENT T. S. RAIFORD: It is my duty and pleasure to convene this, the 111th meeting of the House of Delegates of the Medical Society of the State of North Carolina.

I would first recognize Rabbi Israel J. Gerber of the Temple Beth El of Charlotte for the invocation.

RABBI ISRAEL J. GERBER: Father of all men, Thou master physician by whose hand we have been so wonderfully made, we stand in awe at the infinite genius of Thy creation. Thou hast fashioned man with sturdy bones to wear the mantle of flesh, with abundant fluid to make smooth and resilient the organs of his body, fusing them together to renew every moment the breath of life Thou didst breathe into him, making his clay a living soul.

We thank Thee for Thy children gathered here who devote themselves to the healing of suffering mankind. In the words of Ecclesiastes, give place to the physician, for the Lord hath created him. Guide them, O God, that they may treat skillfully those who look to them for the restoration of health. May they bring relief to the distressed and sunshine where the darkness of illness prevail.

We ask Thy guidance in the struggle against all forms of evil, that Thy children may walk uprightly in the warmth of human love. Keep us far from the sickness of hate and contention, and guide us in new paths whereby we can bring true healing to the spirit and body of men.

Thou that favoreth man with knowledge and teaches mortals understanding, speed the day when Thou wilst reveal the mystery of all illness which baffle the mind of man.

Open Thy repository of health to all who are in sickness, for Thou, O God, art our faithful and merciful healer. Amen.

PRESIDENT RAIFORD: I would now like to recognize Mayor Stanford Brookshire, Mayor of Charlotte.

MAYOR STANFORD BROOKSHIRE: Thank you, Dr. Raiford.

Ladies and gentlemen:

It is my real pleasure and honor to recognize so distinguished a group, and to extend to you the City's greetings and a warm and hearty welcome to the vibrant, progressive, beautiful, growing and friendly Queen City. I like to characterize Charlotte, and I will take just a moment to do so for you, as a city that is large enough to be cosmopolitan in many respects, and yet small enough to be friendly; and certainly I hope it will always remain that small. It's old enough to possess rich traditions and young enough to be strong and vibrant. It's rich enough to be generous and poor enough to embrace hard work. It's proud enough to hold its head high among other cities and humble enough always to lend an understanding and a helping hand.

And with all possession a heart and a social conscience that embraces the needs and the interests of all of our citizens, regardless of race, religion, economic or social status.

Your being here in such great numbers reminds me of what Voltaire had to say about doctors when he wrote "The province of a doctor is to entertain his patients while nature heals them," and how far we have come since that day. We of the laity owe you doctors a great deal for better community and individual health, and for greater life expectancy.

As a layman and as Mayor of the State's largest city, I am pleased to acknowledge your very great dedication and your benefactions to the laity. In turn, I would like to give credit to the citizens of our city and State for their willingness through gifts and taxes to undergird the medical profession with splendid health and hospital facilities, without which of course you could not be nearly so efficient.

Through the cooperation of the taxpayers and benefactors, and our doctors, we share with you the satisfaction of helping to build healthier, happier and more useful lives as we continue to make both material and human progress.

We are glad that you came to Charlotte and hope that your convention will be both successful and pleasant, and that your having met here would add a measured step to the progress of medicine, health and happiness throughout our great State. Thank you for coming.

(Applause)

PRESIDENT RAIFORD: Thank you, Mayor Brookshire, and may I add parenthetically your hospitality you have offered us so far is beyond reproach. Thank you so much indeed.

I would now recognize Dr. Styron, Constitutional Secretary, for any announcements he may have.

DR. CHARLES W. STYRON: No announcements.

PRESIDENT RAIFORD: Now I will turn the meeting over to the Speaker of the House. I will introduce Dr. John C. Reece, Speaker of the House of Delegates.

SPEAKER REECE: The first order of business is a report from the Committee on Credentials.

Dr. Styron, do you have that?

While we are waiting for this, I would like to appoint certain committees. First, a committee to review the two messages from the President: Dr. James Raper will serve as chairman of that committee, and serving with him will be Dr. Lymberis and Dr. Hollister. They will review and report back to the second meeting of the House of Delegates on the two messages from the President.

Dr. Donald Koonce will serve as Parliamentarian for this session.

I am also to appoint a Committee on Resolutions. This Committee is to be composed of the six Commissioners.

VOICE: We have approximately 125 registered, which I believe represents a quorum.

SECRETARY STYRON: This is a quorum.

SPEAKER REECE: The Secretary so declares this is a quorum.

Further the Commissioners will serve as the Committee on Resolutions, with Dr. Wayne Benton as Chairman. We would hope to make a specific announcement of the meeting place of this Committee. It will depend on the length of this session this afternoon. It may be that they can meet following our session here. If not, the Committee on Resolutions will meet at nine o'clock tonight in the Queen Charlotte Hotel.

There is another announcement that I wish to make before we proceed further, and that is concerning the memorial service to be held this evening. We have an outstanding minister all the way from Chicago. I think it behooves all of us to make every effort to attend this meeting at the First Presbyterian Church at eight o'clock this evening.

I would now like to recognize, if they are present, the three student AMA delegates from Bowman Gray, Duke, and the University of North Carolina. If so, will you please stand and be recognized. They may not be here, as their convention is just terminating in Chicago at the present time.

The first official act is a special recognition of Dr. Jacob Harrison Shuford; a resolution has been passed, an Honorary Membership. The Secretary of the Society will now read this:

SECRETARY STYRON: Mr. Speaker:

WHEREAS, Dr. Jacob Harrison Shuford of Hickory, Catawba County, North Carolina, is a native of the State and has carried on in the private practice of medicine since his graduation from medical school in 1936, since being licensed for the practice of medicine in North Carolina in 1936, and

WHEREAS, Dr. Jacob Harrison Shuford in his practice of medicine has at all times adhered to the highest in ethical principles and in the manifestation of services to his patients, and

WHEREAS, Dr. Jacob Harrison Shuford has, through the years of his professional activities in North Carolina, contributed to leadership in his county medical society, and

WHEREAS, his services to the profession through divers committee posts and other eminent official positions in the Medical Society of the State of North Carolina brought his activity into high useful service to the Society and to the people of the State of North Carolina through his manifested leadership at times under such personal sacrifice as to be beyond the call of duty, and

WHEREAS, these services and his manifest leadership prevailed up to the moment at which his health was so seriously involved as to prevent continued participation in the affairs of the Medical Society of the State of North Carolina,

THEREFORE, BE IT RESOLVED, that it is the sense of this House of Delegates that the eminence of the services to this Society, to the public and to his professional associations throughout the State have reached such eminence as to entitle Dr. Jacob Harrison Shuford to recognition by the Medical Society of the State of North Carolina to HONORARY MEMBERSHIP in said Society.

This House of Delegates in Assembly at Charlotte the 2nd day of May, 1965, herewith designates Dr. Jacob Harrison Shuford as an Honorary Member of the Medical Society of the State of North Carolina with all rights and appurtenances appertaining thereto in perpetuity.

SPEAKER REECE: You have heard the reading of this resolution. Do I hear a motion that we adopt

(Such motion was made by Dr. Amos Johnson and seconded by Dr. Ward.)

All in favor say "aye"; Opposed? So carried. This will be forwarded to Dr. Shuford.

We will now recognize our President for his message to the Society concerning his stewardship for this past year.

Dr. Raiford! (Applause)

PRESIDENT RAIFORD: Mr. Speaker, Delegates and Guests: There is a story told of three Tibetan monks many years ago who were bound by vows of silence and allowed to speak only once a year. Two of these monks were working in the field one day when a traveling salesman, we'll say, came by and said "How is the shortest way to get to the Capital?" One pointed over his shoulder.

A year later, the other said "Who was that fellow?"

A year later, the other one said "I don't know."

A year later, the second one said "Talkative fellow, wasn't he?"

At this stage of the year's stewardship, I feel like it might be a relief to join this order, because many of you have heard me speak so many times, and it comes a little bit difficult.

Today, rather than giving you a prepared address, or a prepared speech, I would like to talk from the heart for a few moments touching on some higher spots of our year's activities, and to end with a few observations; and I trust that no Tibetan monks in the audience will say "he was a talkative fellow."

I would call this, at the risk of being somewhat repetitious, the State of the Society message. We have not accomplished any world-shaking changes or changed the course of medicine appreciably. We have attempted, however, to meet the challenges of the every-day matters of medicine as they came, and to deal with them in the most expedient method possible. We have attempted at all times to keep medicine's ship of state on an even keel.

The first matter I would touch briefly on is that which is foremost in your thoughts, that of legislation. You will recall that during the past year, we initiated the Health Opportunities Program last fall as an educational program which was widely received and equivocally received.

Then after the first of the year, and after election, the Elder Care Program was conceived and promoted, and this again was disseminated through a rather widespread educational campaign. Then late in March, and early in April, there came what we might term Custer's last stand. This started and ended on Black Thursday, April 8th.

I think you should realize—and I would take this opportunity to bring to your attention—the fact that our efforts in this State have not been in vain. All of our Congressmen supported wholeheartedly not only by vote, but by influence upon all the neighboring states in this area, the motion to recommit the so-called three-layer cake bill to the House Ways and Means Committee. Unfortunately, that lost by a narrow margin. The bill was then voted upon and passed, and the biggest hurdle has been surpassed by this bill. What happens in the future no one knows.

Other matters of legislative activity pertaining to the State have had to do largely with the nursing bill, the chiropractors' bill, optometrists' bill, and many others with which your Legislative Committee has been thoroughly cognizant, and has handled expediently.

The next item I would like to mention is an unofficial innovation which we have attempted this year in the meeting of so-called Executive Committee within the Council. This committee, unofficial, is composed of the (1) Immediate Past President, the (2) President-elect, the (3) Constitutional Secretary, the (4) Executive Director and the (5) current President, the purpose being to screen the large number of trivial matters, some not-so-trivial but some are quite, before bringing them to the Council.

In this manner, something over 40 items were considered. The vast majority were dispatched quickly. A second group was brought to the Council yesterday for information, and a third group of some seven or eight were brought with recommendations for the Council's action. It is in no way the purpose of this group to usurp the authority of the Council or of the House of Delegates, but simply to expedite the increasing amount of business which comes before the Society.

This year, following the election of Governor Moore, we appointed a committee, a Medical Committee advisory to the Governor, composed of the current officers, (1) President-elect, (2) President and (3) Immediate Past President, four Past Presidents, and the three members, Chairman of the Legislative Committee, whose sole purpose is to act as a liaison body upon request by the Governor for any matters of administration which pertain to the Medical Society and to matters medical.

This has been well received, and while it has not had too much activity thus far, we have had one conference with the Governor, and I believe we have established a good liaison.

Communications this year has been emphasized. We have used the radio, television, the press, for dissemination of any matters which we feel should be disseminated to the members of the Society as well as to the public. Personal contact, whenever possible, personal conversation has been employed. Speech training course was instituted at Durham last December for training of those who would speak before gatherings, both professional and otherwise. And this has been employed and utilized to the fullest extent in disseminating information.

We have increased the communications media of our own central office by installing what is commonly known as Twix, TWX, which is the telegraphic reporter which is connected directly to Chicago, and which does not cost us anything except for the messages emanating from our central office. But it is a means of speeding up communications in times such as in the past few months when time was of the essence.

At the request of the Council, we have instituted a Utilization Committee, and we have gone very slowly on this, because not only has the need existed in the past, but there appears to be an increasing need in the future, if and when the Governmental grab-bill becomes law.

The increasing importance of a Utilization Committee not only in the individual hospital, but in the county societies, will be of tremendous and increasing importance.

We have created or appointed a tripartite committee consisting of representation from the Medical Society, from the Hospital Insurance Council, and from the North Carolina Hospital Association. Our responsibility is only with that segment which is comprised of our members of the State Medical Society. We have no obligations. We have no working agreement with the other two; but it was upon our suggestion that they appointed similar committees, so that in the formation of any policy, this could be done in a relatively standardized manner to be used throughout the state rather than to have each hospital staff or county society do something upon their own, and create a great deal of difference throughout the state.

I have had the occasion to talk with officers from many other state societies and this appears to be the consensus of opinion of the best way this can be handled. We have instituted this, and it will come before the House of Delegates for approval today in the report of the Executive Council.

I would like to mention a word about the financial status of the Society. You will see this later in the report of the Council and the Finance Committee. We have had, as all too many of you know, had to raise the dues this year. I would like to explain very briefly the necessity for this. I won't go into the details of how all the money is spent, but it is simply a fundamental economic principle that in order to keep a business going, it must be supported.

The balance sheet is simply a comparison of income with expense. As to our income, it comes almost solely from dues of the members. To this might be added interest from our investments, and other minor items; but the vast amount comes from dues. The expenses are concerned primarily with the Journal, the headquarters office, travel expense for your officers, and designated personnel, committe budgets, and contributions.

We have examined and re-examined carefully—and the Council requested again yesterday that the Finance Committee re-examine—the budget to see where we might reduce this budget, and reduce the expense without diluting the effectiveness of the Society organization.

I simply bring that to your attention to show you that in order to keep a healthy organization in a solvent state, it does require money, and I can assure you that this additional raise of dues has not been spent indiscreetly nor is it intended to be.

I think I would close with making one or two observations. I would recommend strongly that a continuous supervision of the committees of the Society be maintained, and I believe this duty could be assigned to the so-called Executive Committee within the Council, which committee would be entirely responsible to the Council at all times. But the personnel of this Executive Committee is much more familiar with the personnel, the actions, the functions and the structure of the various committees. I have attempted to explain this in more detail in a recent editorial in the Journal, and I hope that those of you who have read it agree with it in principle.

I believe that we should very definitely increase our intrastate communications. It has been impossible to attend and accept every invittaion tendered me this year; but wherever possible, if it was impossible for me to attend, I have asked one of the other officers — either the President-elect or the First Vice President—to do so, or some properly authorized personnel.

I believe that intrastate communications are just as important, if not more so, than national communications, because unless our own members are informed and educated, and know why certain things come before the Society and certain actions are taken, they cannot support us the way we would like them to.

I would urge, therefore, that at every opportunity during the next year, any society, be it the sectional or a specialty society, a county society, a district society — if you wish a representative of the State Society to be with you, even if it's only to answer questions, communicate through the central office, and we will try to see that someone attends.

I would recommend that we keep to a minimum circularized information. Now this can be a two-edged sword. Some members want to be informed, and this is very frequently the only way we have of keeping you informed. On the other hand, if it gets too voluminous, one of the most difficult jobs is to sort it out and decide which has priority, which shall be read, and which shall be followed.

I would recommend that disseminated directives should therefore be kept brief and minimized in so far as is compatible with the essential dissemination of information from the headquarters office.

I would urge you to discriminate among the extra-curricular activities of the Society. It is an unfortunate thing that many of those among lay groups who are the first to castigate the medical profession are about the first to ask us for our blessing regarding some activity they wish to promote, whether it be an official stamp of approval, active participation or contribution. I think we should be extremely discriminating in deciding which activities we should lend our support to, and to give our blessings.

Finally, I would urge that all officers, all spokesmen, all people who speak with reference to the Society, be extremely discreet in the statements you make, especially before those who may have the priority of disseminating. A great deal can be gained by inference, and inference can be a dangerous thing.

Finally, I would urge you to join me in preserving, in so far as we are able, to the very best of our ability, the treatment of disease and illness as best we know how, regardless of any restrictions which may be attempted by the Federal Government.

I thank you very much. (Applause)

SPEAKER REECE: Thank you, Mr. President, for this inspiring report of your stewardship. This message will be referred and is referred to the Committee to Review the President's Messages.

We come next to the report of the Constitutional Secretary, Dr. Styron, which is published in the Bulletin, the Compilation. Do you have anything to add?

DR. STYRON: The report of the Executive Council of September, 1964, and February, 1965 — there is an error. Motion to grant a request for McDowell County to be transferred from the 9th to the 10th District should read 10th to 9th.

This has been approved by the Executive Council, and will be approved when the minutes are approved.

SPEAKER REECE: The report of the Constitutional Secretary has been presented as in your Compilation. Do I hear a motion that we adopt this report?

(The motion was made and seconded that the report be accepted; motion put to a vote and carried)

The report of the Executive Director, Mr. James T. Barnes.

MR. JAMES T. BARNES: Mr. Speaker and Members of the House of Delegates: You have in the Compilation the report of the Executive Director who serves also as your Treasurer, and the report of the auditor as it appears on Pages 3 to 13 of the Compilation that is in your hands, and finally terminated on Page 63, which constitutes the fiscal report of the affairs of the Treasurer for 1964.

I submit, Mr. Speaker, the original of the auditor's report for the record and trust that the House will find favor and approve this report. Thank you, sir.

SPEAKER REECE: You have been given the Executive Director's report, including the financial status of the Society, with the auditor's report. Do I hear a motion that this be adopted?

(A motion to adopt was made by Dr. Koonce, seconded by several members, put to a vote and carried.)

The Executive Assistant, Mr. Hilliard.

MR. WILLIAM N. HILLIARD: No further report than that printed in the Compilation.

SPEAKER REECE: There is no additional report. This is reported in the Compilation. Do I hear a motion that this be adopted by the House?

(A motion to adopt was made, seconded, put to a vote and carried.)

Educational Consultant, Miss Zeigler.

MR. BARNES: May I say that Miss Zeigler is covering a committee meeting up in the hotel and is not here to add anything, but I think she has nothing to add to the report that is in the Compilation.

SPEAKER REECE: You have the Compilation report. Do I hear a motion that we adopt this report.

(A motion to adopt the report was made, seconded, put to a vote and carried.)

We now come to the report of our Auxiliary President, Mrs. Amos Johnson. Her husband is with her as a distinguished member of this organization, since he is now the new President of the National Association of General Practitioners.

We welcome you as a distinctive new President, and will you please escort our Madam President to the podium.

(The delegates rose and applauded.)

MRS. AMOS N. JOHNSON: Dr. Reece, Dr. Raiford, Officers, Members of the House of Delegates, Ladies and Gentlemen:

This has been a very rewarding year for me.

We in the Auxiliary have tried to emphasize better public relations and reflect the image of the doctor as a dedicated provider of medical services interested in the care and welfare of our citizens. I have the feeling that this we have done.

In your Handbook of Annual Reports, on Page 16, there is a rather detailed report of the many accomplishments of your Auxiliary. Those of you who have studied your lesson have read it and are aware of the tremendous job the Auxiliary is doing. For those of you who have not read it, may I suggest that you do so, for I think that you will be both surprised and proud.

On behalf of the Auxiliary, may I extend grateful thanks for the financial help, wisdom and guidance, and for the patience and understanding from you, your officers and your staff. With your help we have an increase in membership. At present we have passed the 2500 mark — not much, but we're over it. And we have a renewed interest in the work of the Auxiliary.

Please continue to show your interest and enthusiasm, and we shall continue to do your bidding in any way that you see fit.

When I started working on this report, Amos told me that rather than use the old ABC's of a good report, that I should use the 3-S's: stand up and be seen; speak up and be heard; and shut up and be appreciated. (Applause)

SPEAKER REECE: Thank you, Mrs. Johnson, for your report. This is published in the Compilation. Do I hear a motion that this be adopted?

(A motion to adopt the report was made, seconded, put to a vote and carried.)

We now proceed with the order of business of the House. First I am to announce, as I did a few minutes ago, the Reference Committee, with Dr. Benton serving as Chairman, Dr. Wilson, Dr. Lindsey, Dr. Welton, Dr. Maness, and Dr. Thurston on this committee, they representing the Commissioners.

We come now to the final consideration of the House of Delegates on the 1964 House of Delegates action on scientific membership. I hereby recognize Dr. George Paschal.

DR. GEORGE PASCHAL: Mr. Speaker, President Raiford, Madam President, Members of the House of Delegates, Ladies and Gentlemen:

I thought Ted was going to tell the story about the three monks that I heard about, which might be applicable to this particular occasion. My monks were in an order where they pledge silence, and they remained in silence for five years at a time, breaking that silence only upon election by ballot. And when the first five years went by, one of the monks was chosen, and all of his friends were anxiously waiting to hear what he was going to say. When he arose to speak he said only "I don't like oatmeal."

He sat down, and everybody was disappointed, but they maintained their silence for another five years, and again they came to the same occasion, and the second monk got up and he said "I do like the oatmeal."

Five years later, another monk was chosen to speak, and he came to the podium, and all of them were in rapt anticipation of what was going to be said. He said "I'm going to renounce my vows, return to the world. I just can't stand this argument about the oatmeal."

A year ago in this session of the House of Delegates, there was a recommendation by President Rhodes which was an action of the Council taken the preceding day which had to do with the matter we consider today. At that time the proposed amendment was made, and it was properly made. There was no action to be taken at that time, but it complied with the rules and regulations of our Constitution and By-laws, and further it was to lie over for a year to be considered for action at this particular meeting.

In addition to that, it was to be duly published, which was done, circulated to the membership, so that everybody would know the full content of the proposed amendment and the changes it would involve.

I would report from the minutes of the House of Delegates, and I will take the liberty of reading it so as to be absolutely correct about my interpretation in passing it on to you. Dr. Rhodes said at that time that the Council passed on this motion, and passed it on to the House of Delegates for their further approval. It was in this way: "that this Council approve and asks the House of Delegates to further approve the change in our Constitution and By-laws which will make it possible for any person who meets the specified requirements of membership to be granted such membership in the Society as an active member."

I would like to also add that at that time, Dr. Rhodes reported to the House of Delegates that he thought it was only fair that the House know that the vote taken by the Council was 10 to 5 in favor of this motion, with two members being absent.

This motion at the House of Delegates was considered individually. Other matters have been included in his earlier motion, and this matter was read a second time, and Dr. Rhodes said at that time "Finally, I will repeat very briefly what I said at the beginning of this report. After deliberation in two sessions of the Council, this matter was deferred in the January meeting until the May meeting; and after further consideration, the motion was made that the Council approve and ask the House of Delegates to further approve the change in our Constitution and By-laws which will make it possible for any person who meets the specified requirements of membership to be granted such membership in the Society as an active member."

Again he pointed out that the vote was 10 to 5, with two men being absent. It was at that point

that I rose to speak to the Council's recommendation. I make this statement now, and it is quoted as it was given at that time.

In order to implement the recommendation of the Executive Council, and in compliance with the provision of the Constitution and By-laws, Article XIII, regarding amendments I present the following specific amendments to the Constitution and By-laws. The amendments proposed are as I will read them:

To amend Article IV of the Constitution and By-laws by striking out the words "scientific members" in Section 1.

Two, by striking out the words "other than scientific members" in Section 2.

And three, by striking out Section 8 entirely.

And to amend the By-laws as follows: By striking out the words "scientific members" in Section 1 and inserting the word "or" between the comma and the word "affiliate."

Amend Chapter 12, Section 1, by striking out the words "and scientific members." That's on Page 34.

Amend Chapter 15 by striking out the word "white" and in Line 5 of Section 5, striking out the semicolon in the portion of the first sentence after the word "members" in Line 7, and inserting a period after the word "members."

And finally by striking out the last, or the remainder of that particular sentence.

I move that this motion be approved by the House of Delegates.

SPEAKER REECE: You have heard the motion that this be approved by the House of Delegates. Do I hear a second?

(The motion was seconded by several delegates.)

DR. PAUL F. WHITAKER: Mr. Speaker, and Mr. President, members of the House of Delegates to the Medical Society of the State of North Carolina, Ladies and Gentlemen:

I wish to state at the beginning that I oppose this amendment to our Constitution and By-laws. At the same time I realize that I do not want to create a great controversy. I have that much respect for your incoming President, Dr. Paschal. I do not wish to add to his burdens, or the burdens of our present officers. But I would like to speak to you very briefly on this subject.

Ten years ago, I stood before this body of our Medical Society and presented the report of one of our committees consisting of Dr. Brewer and Dr. Royal and myself, advocating the admission of Negro physicians to this organization as scientific members, which granted them the right to attend all clinical sessions, to vote, and to hold office.

This membership was eventuated with considerable difficulty, including a change in the Constitution and By-laws of the Society. The report upon which this action was based was published in the North Carolina Medical Journal, and I assume that

all delegates to this session of our Society have read it.

Some weeks ago a chronological report on the events or happenings subsequent to the 1955 action was sent to all delegates assembled here today. Dr. Raiford stated that was not done in an attempt to influence anyone's opinion, but merely as information. I assume that all of you have read these two reports, and I believe it would be necessary to read them in order to vote objectively and intelligently on the issue presented before us in the best interest of our Society, which you represent, and the present and future membership of our Society, both Negro and white.

The issue before us now, as I understand it, is another constitutional change in order to allow full membership in this Society to Negro physicians, thereby repudiating in effect the action taken in good faith ten years ago, and yielding, as I see it, to the continuous and militant pressure and threats to which the American people, including the physicians of the nation, and the members of this Society, have been subjected.

I am opposed to the proposed constitutional change for many reasons which I consider to be sound. They are outlined in the material which has been made available to you, and I do not propose to take your time to repeat all of them. Suffice it to say here that this Society in 1955 met the aspirations of the Negro physicians of North Carolina concerning membership as their then constituted leaders stated them to be, and the action by this Society was almost without exception commended by the newspapers of the State.

Following this action, some Negro physicians joined the Society in good faith, became members of the American Medical Association, and as a result were subjected to censure by their colleagues and their Negro organization for so doing.

This Society was accused and criticized in the press by Negro physicians for offering what they term "second class or inferior membership." The scientific fellowship available was referred to as degrading. Accusations were made of unilateral action, and most of the Negro physicians refused to join the Society in the membership offered.

Here the matter rested until 1961, when the then President of the Negro Medical Society approached the President of the Medical Society of the State of North Carolina, at that time, Dr. Johnson, and asked that the question be reopened. The happenings since then are available to you, and I am sure that you are familiar with them.

Suffice it to say again the matter was considered at length in committee, and then at the request of your committee, in accordance with the request of the Negro physicians, by your Executive Council of this Society. Before the meeting of your Executive Council and previously in committee the chief spokesman for the Negro physicians said that the membership which this Society in the utmost sin-

cerity and good will offered and changed its Constitution to offer was second class, inferior, and also dehumanizing. That full membership, which they insist upon without giving the membership offered a try, is inevitable. That while his daughter was marching in picket lines, to accept less than full membership would be letting her down; and that if they accepted the membership offered, they would "lose leverage to move forward."

This latter statement was made despite our assurance to the contrary.

While negotiating with us, he expressed himself in writing to the American Medical Association that they should pressure this Society to grant them full membership. More recently, as you know full well, the Old North State Medical Association — that is the State organization of Negro physicians — and their national organization, have taken official stands on the so-called Medicare legislation diametrically opposed to the stand of this Society and the American Medical Association.

In this connection, I quote from the Raleigh News & Observer of April 12, 1965, a statement by Dr. Eaton, the present President of the Negro organization. Asked about the possibility that the Negro physicians' stand on Medicare could influence the vote and delay integration, meaning the vote that you will take here today, Dr. Eaton said, and I quote him "If it does, we don't care. If they don't vote us in, we're going to sue."

Now, ladies and gentlemen, the defiance and threat in these remarks is self-evident, and more importantly, it is an evident fact that the Negro physicians have made the membership in this Society an integral part of the drive for so-called civil rights, and an instrument of pressure for an integration of the races.

This, in turn, is a part of the fabric of a movement which is proceeding with ever-increasing success to eventuate a society of socialism in the United States of America. Both in your Liaison Committee and before your Executive Committee, the Negro physicians both directly and indirectly referred repeatedly to the pressure to which they were being subjected on this question. They did not, as I remember, name the source of this pressure, but I think all of us know where this pressure is coming from. It comes from the National Association for the Advancement of Colored People, the Congress of Racial Equality, and the American Civil Liberties Union, which are all socialistic creations. I make that statement, and I think I can document it.

I am speaking only as one delegate, and I do not wish to get the Medical Society of the State of North Carolina in any difficulty with a statement of this kind. I take full responsibility for saying they are socialist creations, and I can document what I have to say.

There are other organizations involved, some formed decades ago, and some only recently, which are involved in the movement to bring socialism to the United States.

Time will not permit my discussing them, but I say here that the League for Industrial Democracy, LID, formerly known as the Intercollegiate Socialist Society, with offices in New York City, is a tax-exempt Fabian Socialist nerve center for the United States.

To briefly substantiate and document the statements I have made as to the organizations referred to, and in order not to be accused of being a right-wing extremist, or super-patriot, or John Birchite, which I am not — to briefly substantiate and document what I say of the organizations, I quote one paragraph from the book by Mr. Archibald Roosevelt, son of President Theodore Roosevelt, distinguished socialist and citizen, and Mr. Sigmund Dobbs, Research Director of the Veritas Association, entitled "The Great Deceit."

"An amazing interlocking series of organizations have been formed to put across forcible Negro-White integration in the United States. The NAACP concentrates mainly mainly in rallying Negroes and furnishing the facade for legal actions. CORE is devised to organize direct action campaigns, such as demonstrations, sit-downs, and so-called freedom riders. The ACLU, American Civil Liberties Union, on the other hand, runs interference in the legal field for all of these moves. The ACLU is a name too used to undermine the basis of the American legal system. It has assumed a permanent post of a disinterested party claiming to represent civil liberties for all. In this it has been exceptionally clever.

"However, extensive analysis shows that the NAACP, CORE, and ACLU, have all been formed and are controlled by socialists. Since there is generally some sort of working rapport between Communists and socialists, there is naturally a generous sprinkling of pro-Communist elements in all of these organizations.

"The activities of these groups have produced a sickness of our society. Some of the symptoms of this sickness are apparent for all to see. In the name of so-called socialized law, the Constitution of our country has been twisted and tortured; American jurisprudence debased; the science of man blacked out; our shrines and heroes degraded, and mediocrity enshrined.

"Mob rule is rampant in our streets. Private property is being violated and pillaged; Fabian Socialists have been in high positions in government, and ecclesiastical politicians through the National Council of Churches are engaged in lobbying and presuming to speak for other people in areas which they have no training, and for which activities they have no mandate."

This sorry, sad, and tragic spectacle is available for all to observe.

I say to you, my fellow delegates, that membership in this Society, and for which it is now pro-

posed to make another constitutional change in order to permit it, has now gone far beyond the simple question of membership. It is part of an organized effort, as I see it, to change the pattern of our civilization into a socialistic society, including racial integration.

Much of this is being done in the name of morality, and pseudo-social science, and of Christianity. As I see it, nothing could be further from the truth. There is nothing moral, Christian, or scientific about this movement.

We are being told that these changes are inevitable. Of course, they are inevitable, if men and women of good will like you accept them and fail to protest them.

Ten years ago, this Society took a position that was fair and high-minded. It was in keeping with the best in our professional attitudes, history and tradition. It was commended, again I say, by the press of our State.

Now under persistent false and basically evil pressure — and many members of your committee can tell that this is true — we are being browbeaten into retreating from it. It has been maligned and spurned, and now openly threatened without giving that position even the vestige of a fair trial.

It is my belief — and again I wish to cast no aspersions on any member who differs with me, and I'm sure that many of you do — that a position taken in dignity, honor, sincerity, and with the utmost good will, should not be abandoned until we as an organization are legally forced to abandon it.

I am sure that every delegate assembled here, along with me, would yield to none in his feeling of good will toward the Negro physicians and the Negro race. As I see it, they have been pressured and misled, and have become a part of a movement that bodes nothing but ill for this Medical Society and the overall American Society of which we are a part.

It is my hope that you will give consideration and oppose this Constitutional amendment.

I thank you for listening to me. (Applause) SPEAKER REECE: The Chair recognizes Amos Johnson.

DR. AMOS JOHNSON: Mr. Speaker, President Raiford, members of the House of Delegates, fellow physicians and friends: You are having passed out to you at the present time for your perusal and reading — so that you don't have to attempt to evaluate from listening to word of mouth — a proposed substitute resolution, and it will require that I be given permission by this House of Delegates to introduce this resolution if you are to receive it.

In asking for this permission, I would like to assure you that this is no red herring, that it is not a delaying tactic, that it is not a degrading tactic, that it is a new and in some respects novel ap-

proach, certainly for the State of North Carolina, to this problem which poses the possibility and potential of causing some area of disagreement within our Medical Society of the State of North Carolina, and I would like your permission through your Speaker to read to you this resolution.

SPEAKER REECE: You have heard the request. This will require the suspension of the rules.

DR. KOONCE: A two-thirds majority.

SPEAKER REECE: And a two-thirds majority of the delegates. Do I hear a motion that Dr. Johnson be granted —

DR. WAYNE BENTON: Point of order. The Constitution and By-laws, on Page 5, Article V, the House of Delegates shall be the legislative and business body of the Society and shall consist of (1) delegates elected by the component county societies, and (3) ex-officio the past presidents, past secretaries, and the officers of the Society as defined by the Constitution.

He is a member of the Society. He does have a right to vote.

SPEAKER REECE: I don't understand that that relates to our problem here.

DR. BENTON: He does not have to ask permission to bring a resolution. He is a member of the House of Delegates.

DR. JOHNSON: My understanding is what you have said, Dr. Benton, is entirely correct. I am a member of the House of Delegates here. I do have a right to introduce a resolution, and I do have a right to the floor. But the timing of the introduction of this resolution is the matter at hand, and it is out of place timingwise; and it does require that two-thirds of you here grant me permission to do this. Otherwise I will sit down, and with no prejudice I will sit down. But it does require an action involving two-thirds of the members of the House of Delegates.

DR. KOONCE: Mr. Speaker, as Parliamentarian, may I clear this up? Section 18 of Chapter 4, "No resolution shall be considered or voted upon by the House of Delegates unless the resolution has been filed with the Executive Director of the Society at least sixty days before the first meeting of the House of Delegates, except upon a vote of two-thirds of the members present at the House of Delegates, or upon reference to the House of Delegates by the Executive Council."

DR. MILLARD HILL: I move that Dr. Johnson be granted permission to read the resolution.

(A standing vote was taken.)

SPEAKER REECE: 147 voted; 86 voted for introduction, and 61 against. Therefore, the Chair rules that it cannot be presented.

Dr. Johnson does have the right to speak from the floor.

DR. JOHNSON: Now that the motion shall not be presented, and I am not upset or hurt, nor shall I fail to sleep tonight, because I am not

crusading for any specific resolution or answer to this problem.

You all have it before you. You all will read it. As a matter of fact, in discussion, it is my perfect right to read the resolution to you now. You just won't have the authority to act upon it, because my parliamentary rights do permit me to talk about this.

This was not, I'm sorry, put together in time to be presented through normal channels. This came as a result — certainly there are some innovations in it — of thought given since arriving in Mecklenburg County, and since talking to many of the delegates here, some who were very much opposed to this idea, and some who were in favor of it, some who voted for the introduction, and some who voted against it.

To me it presents, as you will read it and study it, an implementation of a rather sticky and touchy mechanism into our State Medical Society which could, with dignity, permit the people who have been, let us say, discriminated against after a manner — permits them with dignity to participate in the formulation of an organization in which they can take some pride, and indeed look to as somewhat a product of their own cooperative work.

The idea, to me, that these people will take pride in the passage of the resolution which will presently be put before you is a little bit difficult for me to come by. The type of pride that will be taken will not be the healthy pride. When this marriage is consummated, which I believe it will be in just a few moments, it will not be a marriage of love, I'm afraid, as could have been the proposition that you have before you, and which I hope you will read.

This was not a delaying action. This could be implemented equally as quickly, maybe more quickly, than the other one which may be passed.

There are mechanisms whereby the entire population of our Medical Society can be polled within a very few days after this meeting, and an amendment such as this implemented without having to lay on the table for a year. And this was what was envisioned; and even though this would have taken a little bit of time to implement, there was a mechanism put into this resolution which would afford membership as of the present time when the resolution was passed, because it in itself to a point did implement the motion which now remains before you in the House.

I had hoped that we might be able to have this sent to a reference committee where, without passion, with malice towards none, we might have tonight sat down and talked this proposition through, so that when we go home from here, we would go home two or three days from now as a united group, each having heard the other out, being fashioned after a manner of a democratic organization. But you have spoken, and I respect your vote, and I have no ill will.

DR. DAVID G. WELTON: I wish to speak to Dr. Paschal's original motion.

Mr. Speaker, President Raiford, officers and fellow members of the House: At a meeting of the 7th District representatives on April 22nd, after full and free discussion of all aspects of this matter, the consensus of opinion was to support the passage of this amendment, and I was requested and authorized to present this statement to this group. By a consensus, I mean not only a great majority of those present, but also those contacted subsequently who had not sent representatives to that meeting.

Now I wish to speak as an individual, and I wish to state that I am in favor of this amendment. I believe strongly that since it has received full and serious consideration for an adequate length of time, it is both wise and appropriate for us to make a decision upon it today. I do not believe further delay is justified. I would like to quote to you from Thomas Carlisle as follows:

"Our grand business is not to see what lies dimly at a distance, but to do what lies clearly at hand." Gentlemen, I think this lies clearly at hand.

Thank you. (Applause)

DR. ERNEST CRAIGE (Durham-Orange): I would like to report the sentiments of the Durham-Orange County Medical Society which met on April 14th to consider this matter and voted unanimously in favor of the proposed amendment.

As everyone knows, and as Dr. Whitaker has so eloquently said a few minutes ago, this proposal is going to go through inevitably one day, and the choice before us here is whether we would accept this voluntarily and make this favorable vote which would do a great deal to heal the rift between the races.

There are other days in the future, as he has pointed out, that the same essential result might occur through lengthy litigation, which might have unsavory effects for the entire Medical Society. I don't favor this proposal merely because of the threat of litigation, but rather because I think it's right.

We appreciate very much the dedicated work that the committees have done during the past ten years who have wrestled with this problem, but I think that the arguments and the propositions of the 50's are really no longer relevant to the problem.

In 1965, it is really inappropriate for an organization such as ours that is dedicated to humanitarian and scientific principles, that we should be spending our time and our energies continuing to debate this proposition.

I personally feel that if we persist in our former— in our up-to-now rules and former practices, which I believe to be legally untenable and indefensible, and above all these are not in the best interests of our patients, we cannot succeed. At a time when there is agitation in the East and in the

West for more medical schools in order to provide more general practitioners for the patients in our State, we find that there is a small number of qualified physicians. Some, I noticed, migrated from Charlotte a few days ago, and we have graduated several excellent physicians from the University, some of whom have received the AOA, the highest academic distinction; but the number of those who come back to practice in the State in a small minority of the total. It seems uncomfortable to me to carry on restrictive practices which make the profession of medicine unattractive for these very well qualified individuals.

I therefore hope that we will pass this amendment today so that all physicians who are scientifically and ethically qualified can be equally members of this Society.

(Applause)

DR. BRUCE B. BLACKMON (Harnett): I would like to ask one question and then speak to this also.

Is this the final reading, if we vote on this now? Is this motion being carried or defeated as is?

SPEAKER REECE: Yes; this is a final presentation before the House of Delegates for final action.

DR. BLACKMON: Thank you, sir.

I am caught in the position, like my good friend Dr. Welton from Charlotte, of coming instructed from my county, from Harnett. The problem is that I was instructed to vote the other way. Now we are at cross purposes.

I am very much concerned about this overall problem. I think that it needs attention and needs to be settled; but I think that we are going at it through a parliamentary procedured gadget. Dr. Amos Johnson has presented a possible solution here that might satisfy most of the group. The vote was 80 to 60 in favor of that, and yet because of a parliamentary situation, we cannot review that and study it. I would like for us to study all the various possibilities that we have, and then come up with the best solution.

This convention is in session from now until Wednesday, and we can take as much time as necessary to study this and come up with a good solution.

With that in mind, and this is a parliamentary procedure gadget, of which I am very much opposed, I would move that we lay this on the table, so that it will clear the floor, and we can discuss anything we need to discuss; and then when the proper time comes, I shall be delighted to help take it from the table.

SPEAKER REECE: You have made the motion that this be tabled.

(The motion was seconded.)

All those in favor say "aye"; opposed "no." The noes have it.

DR. PHILIP NAUMOFF (Mecklenburg): I am Chairman of the Public Relations Committee of the

State, and I would like to speak in that capacity. This State has been going through the motions of what to do about this situation now, as presented, for ten years.

It is my job in this State Society to present to the public the best public image of the physician in the State of North Carolina. In fact, tomorrow at twelve noon, we are going to present to a television star an appreciative award of what he is doing to present a good public image of the physician to the whole United States.

We, too, in this State, must present to our lay people as well as to ourselves what we feel is the best public image of ourselves. We are leaders in this State. We are members of a very fine profession. We are supposedly intelligent.

At the present time, we are under surveillance, not only by the local newspapers, but by national coverage. I know for a fact that we have representatives here from Medical Economics. We have representatives from the Associated Press, the United Press International; we are watched very carefully to see what this particular state is going to do regarding this particular issue.

I can also certify and state that if we permit this issue to go to the courts that it will do us no good whatsoever as far as our public image is concerned. We must, in order to preserve the best possible face that we have, as far as our public is concerned, as far as our patient is concerned, and as far as we know is absolutely the right thing to do — we must go ahead and vote for passage of the change in this Constitution. Thank you.

DR. POTEAT: I call for the question, Mr. Speaker.

DR. CHALMERS R. CARR (Mecklenburg): I would like to state that as before our Society is almost unanimously in favor of the passage of this amendment, and that has been said and is well known. We have been polled, and we have some dissenting opinions for various technical reasons; but I want to state publicly that we are in favor of this amendment.

Since reading seems to be in order, I wish to read a brief paragraph from the Constitution and By-laws of the Medical Society of the State of North Carolina, Article II, under the Preamble, Purposes of the Society:

"The purposes of this Society shall be to federate and to bring into one compact organization the medical profession of the State of North Carolina, and to unite with similar organizations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and the advancement of medical science; to elevate the standards of medical education and medical service; and to promote friendly intercourse among physicians; and to enlighten and inform the people with regard to the great problems of medical care and public health, so that the profession shall become more capable and honorable within itself,

and more useful in the prevention and cure of disease, and the prolonging of aid and comfort to life."

There is a qualifying section later on which restricts the Society to white physicians. But without saying more, I appeal to each of you to return to the basic tenet of Article II of our Constitution. Thank you.

(Applause)

SPEAKER REECE: The Chair wishes to give everyone an opportunity to be heard, but we do not want to prolong this discussion unnecessarily.

DR. MARVIN M. LYMBERIS (Mecklenburg): My remarks will be very brief. I have been in this body for over ten years. I have wrestled with this problem. I have heard all of its arguments.

I do not think that the issue before us today is whatever the action of the Old North State Medical Society has been or has not been. There is no proposal before this body of a merger of the Old North State Society. I do note that the issue before this body is whether it is expedient for the North Carolina Medical Society to take in the Negroes as full members or not. The issue is not a legal one. I think we are all sure of what the legal position should be, should this be tested in the court.

The issue is not whether it would serve our fight against socialism or not. There is but one issue before this body. Is this right? Is it morally right that we accept all qualified physicians of this State?

Our oath, based on Hippocrates, which antedated the civil rights law by over three thousand years, is clear on this position. We do not have to apologize for legislative efforts. We do not have to apologize because threats and coercion have been made against this Society. I say let us take this stand not as a result of threat, not because this or that individual is deserving or non-deserving of membership, but because it is correct and right that all physicians shall be a member of this State Society to promote the well being of the general public, and the general interest of the physicians into a better and higher standard of the practice of medicine in the State of North Carolina.

(Applause)

DR. J. STREET BREWER: Fellow delegates, I would like to say just a few things.

First of all, as most of you know, I was a member of the original committee that studied this question. I was in Kinston at the first meeting we had with the Negro physicians when Dr. Paul Whitaker, Dr. Ben Royal and myself as a committee — Dr. Hill was there as Secretary of the Medical Society of North Carolina, and Dr. Roscoe McMillan was there as Chairman of the By-laws and Constitution Committee.

We heard those men out and had a perfectly free and frank discussion with them, and the report drafted by Dr. Paul Whitaker came up and gave them everything they asked. They were asking for full scientific membership. They told us that they understood the mores of this country, and the customs, and they could not expect to obtain social acceptance at that time.

Of course, you know since then things have changed. It has been implied that these men have had a sort of inferior or second-class sort of membership. I would like to call your attention to the fact that any newspaper reporters here today, please remember this: This scientific program that we have for these doctors gives them the right to vote or hold office.

If they had joined, as they had an opportunity to do, some of them could be sitting here in this House of Delegates today, if they had gotten themselves elected. But they chose to ignore, and censured the few that did take advantage of the opportunities we offered them. Why did they do it? Because they asked for only one thing, and that is to take down the social customs of this country.

They have everything a full membership can give them them now, except the opportunity to attend the banquet and to dance on the floor with our women. Now if you want to break down all the social mores and all the social customs that we have been accustomed to in this section of the country, then enact this legislation. But I call your attention to the fact that they have every privilege now except that, and that's all you're giving them additionally if you pass this resolution.

I would like to register my opposition to it.

SPEAKER REECE: The Chair will therefore call for the question.

All in favor of the motion, the resolution as introduced by Dr. Paschal, say "aye"; opposed "no." The "ayes" have it.

DR. KOONCE: I call for a count.

DR. JOHNSON: I ask you if this is not to be also a two-thirds vote.

DR. KOONCE: I call for a count.

SPEAKER REECE: I understand the Parliamentarian tells me it does not require a two-thirds vote.

DR. JOHNSON: May I ask the legal talent we have?

DR. KOONCE: Yes, it is a two-thirds vote.

DR. BENTON: Page 8 of the Constitution and By-laws, Article VIII, Amendments: The House of Delegates may amend any article of this Constitution by a two-thirds vote of delegates registered at that meeting, provided that such amendment shall have been presented in open meeting" — it's two-thirds here.

SPEAKER REECE: All in favor stand please.

Dr. Wilkerson, can you give us the total number registered at the present time?

DR. WILKERSON: Mr. Speaker, we have 144 registered delegates, and then we have the additional past presidents and past secretaries, and members of the House of Delegates at large, which brings the total registered to 154.

SPEAKER REECE: 117 voting for the resolution and 28 against. Therefore, the Chair declares that it has been carried.

Dr. Paschal wishes to be recognized.

DR. PASCHAL: Mr. Speaker, we are well aware that this poses problems for certain areas. We want to maintain harmony in our organization. We want to maintain harmony at local levels. We don't wish to deny any county society the privilege of operating as they desire.

In view of this, we recognize that the Constitution and By-laws spells out the fact that the portals of entry are through the local medical society. There are provisions at the present time whereby an applicant for membership in the local society for the State Society can be denied membership but he has the privilege of applying to the Council for membership, and will be admitted pending their action.

In order to make it so that the local county societies can carry on without being in conflict with the Constitution and By-laws of the State Medical Society, we have prepared, or the Committee on Constitution and By-laws has prepared certain changes which I think will be spelled out, which can be spelled out, and which I think will satisfy each of the local components.

I would like to move that the By-laws be changed to accomplish this, and this can be done at this meeting. It can be passed today and ratified two days later at the next session of the House of Delegates, and it can be put into effect at that time

And with these things in mind, I move that the By-laws be changed to accomplish these purposes, subject to your approval following hearing them as spelled out by the chairman of the Committee on Constitution and By-laws.

I make that motion, Mr. Speaker.

 $SPEAKER\ REECE$: You have heard the motion. Is there a second?

(The motion was seconded.)

DR. PASCHAL: That is, of course, subject to the approval of the House of Delegates. They can do what they want to do about it.

SPEAKER REECE: All in favor say "aye"; opposed "no." So carried.

Since we are dealing with the change in the Constitution and By-laws, we will go to Section D (6), Report of the Committee on Constitution and By-laws.

DR. ROSCOE D. McMILLAN: Mr. Speaker, members of the House of Delegates: Amend Article IV, Section 2 of the Constitution on Page 2, by inserting the word "active" between the words "the" and "members." The Section will then read:

"Active members of this Society shall be the active members of the component societies, and those physicians who are admitted by the Executive Council as hereinafter provided.

Amend Chapter XV, Section 5 of the By-laws

(page 39) by adding this new sentence after the word "members":

"A county society may admit other members upon such basis or classification as it may determine." The Section will then read:

"Each county society shall be the judge of the qualifications of its own members, but, as such societies are the portals to this Society and to the American Medical Association, only reputable and legally registered physicians who are practicing, or who will agree to practice, nonsectarian medicine, shall be admitted as active members. A county society may admit other members upon such basis and classification as it may determine."

Amend Chapter IV, Section 11 of the By-laws (Page 14) by deleting the present section and inserting a reworded section to read as follows:

"The House of Delegates shall have authority through the Executive Council, by majority vote of the Council, a quorum being present, to elect to membership any reputable and legally registered physician who applies directly to the Society for membership as provided in Article IV of the Constitution, when such physician has been definitely refused admission to a local society, and he has appealed to the Executive Council for membership and where, after hearing, the Council is convinced that such physician is eligible for membership in the State Society and that it is impossible to reconcile the local society to admitting him. The Executive Council shall certify the election of such physician to the Secretary. A member so elected shall, on payment of annual dues and assessments for the current year, be entitled to the rights and privileges of membership as provided by Article IV of the Constitution."

These changes are recommended for the following reasons:

- 1. A county society can be assured it can be the judge of its membership, admitting or rejecting whomever it will without being "in conflict" with our Constitution and By-laws. A county society may retain a "scientific membership" if it wishes, and it may, as some have, admit dentists and pharmacists or other non-physicians to its membership in a classification other than "active" membership. But only its active (physician) membership can be active members of the State Society.
- 2. If a legally registered physician is other than an active member in a county society or if he has been refused membership in it, he may apply directly to the Executive Council for that class of membership in the State Society for which he is eligible.

Mr. Speaker, I move the adoption of this supplementary report as an essential implementation of Constitution and By-laws effectuating an earlier affirmative action today of the House of Delegates.

(The motion was seconded by Dr. Hollister.)

DR. LOUIS SHAFFNER: I am a member of

the Committee with Dr. McMillan, and I would like to draw to the attention of the House that this extra paper which you have just received, the first one is an amendment to the Constitution and would not take action today, but lay on the table for a year.

But the second change and the third change would be changes only in the By-laws which can be acted on today and ratified at the second meeting.

SPEAKER REECE: This, of course, would represent the first presentation and a vote today would be again presented to the House at our second meeting on Tuesday afternoon. The first part would stay over to next year.

A MEMBER: When this is amended next year, you're still not getting anywhere, because you still cannot take in these members this next year.

DR. KOONCE: Wasn't that included in your motion that you made last year and was reaffirmed? The change in the Constitution —

DR. PASCHAL: I have to check specifically what I said.

Article IV — I don't see that in what I did read — the word "active" in Article I of Paragraph 2 is the word that I did not read last year.

DR. KOONCE: But what you did read would implement taking in —

DR. PASCHAL: What I did read would fully implement — that was proposed to provide implementation for the amendment.

SPEAKER REECE: You have heard the motion made and seconded. All in favor say "aye"; opposed "no." The "ayes" have it; so carried.

A MEMBER: A motion was made last year with regard to the election of Councilors. Isn't that to come to the floor this year?

DR. REECE: Dr. McMillan is going to report on that under his change of Constitution and Bylaws later on.

We will proceed now with Councilors' reports under B.

These have been published, of course, in the Compilation. We will accept the Councilors' reports, unless there is something new to be added. We will accept them all in a body.

(No Councilor had anything to add.)

SPEAKER REECE: Do I hear a motion that we accept the Councilors' reports as published in the Compilation?

(Such motion was made, seconded, put to a vote and carried.)

SPEAKER REECE: Do I hear a motion that we accept the report of the delegates to the American Medical Associtaion as in the Compilation?

(Such motion was made, seconded, put to a vote and carried.)

North Carolina Board of Medical Examiners, Dr. Combs, Secretary.

(No additional report.)

Hospital Saving Association.

(No additional report.)

Hospital Care Association, Dr. Street Brewer. DR. BREWER: I would like to mention just two items that were not available at the time this report was made. One is that under the Hill-Burton Hospital Building Care Program that we have in operation in this country, North Carolina has completed more projects, total projects, including health centers and hospitals, than any other state. They have also completed more hospitals than any other state.

Now we have not completed the number of beds, as in some states like Texas, New York and Illinois. And one other thing that is of interest. We as the Commission supervise the expenditure of well onto 200 million dollars since 1947, and that's been done at an administrative expense of a little less than 1 per cent. That is significant because the Governor told us recently that that that was the lowest administrative expense of any department in his government in the State of North Carolina. (Applause)

SPEAKER KOONCE: Thank you, Dr. Brewer, for that additional report.

American Medical Education Research Foundation, Dr. Underwood.

(No additional report.)

These reports have been published in the Compilation. Do I hear a motion that we accept them? (Such motion was made, seconded, put to a vote and carried.)

Now the report on Constitution and By-laws, Dr . McMillan.

DR. McMILLAN: Mr. Speaker, members of the House of Delegates: Your Committee on Constitution and By-laws has met on two occasions during the year — during the Conclave of Committee-Commissioner Conferences in Mid Pines in September 1964, and again on February 6, 1965, in Pinehurst. Several important matters of referral have been considered and resolved into recommendations to the House of Delegates which will follow:

Item 1. Article VIII; Amend Article VIII, Section 3, line 9 by striking out the phrase: "who is not in attendance upon the annual meeting and" — and in lines 16 and 17 the words "including the meeting at which he is nominated."

I will explain that to you. This amendment, acted on by first reading in the 1964 House of Delegates was essential due to the secrecy of the Nominating Committee's sealed report of nominations to the President, whereas those nominated therein would scarcely have knowledge they were nominated for elction and might or might not have been at the annual meeting at which they were elected as required in the prior form of the Constitution and By-laws.

I move the adoption of this amendment on final reading.

SPEAKER REECE: You have heard the motion.

(The motion was seconded, put to a vote and carried.)

DR. McMILLAN: Item 2. Amend Chapter 10, Section 16 of the By-laws by inserting in line 1, page 34, after the words "Doctors' Plan" the following:

". . . and to advise and counsel concerning matters related to Blue Cross, indemnity coverage, extended benefits and major medical coverage administered by Hospital Saving Association and Hospital Care Association, as requested," —

This change was brought about by the fact that a Committee on Blue Shield over the past eighteen years has been called upon to confer, consult and advise the two associations in respect to the medical aspects of administration of their respective indemnity insurance programs and it was the sense of the Committee and the Executive Council that this should be an authorized function of the Committee.

I move the adoption of this amendment.

(The motion was seconded, put to a vote and carried.)

Amend Chapter 10, Section 19 by deleting the words "except the Committee on Nominations and Committee on Grievances" and substituting in lieu thereof: "except as otherwise provided," —

I move the adoption of this amendment.

(The motion was seconded, put to a vote and carried.)

Item 3. The Committee is cognizant of a motion presented in the House of Delegates, Sunday, May 3, 1964, which motion was put by delegate Bruce Blackmon, M.D., Harnett County Medical Society, as follows:

"I move that next year the Constitution and Bylaws Committee present to this House of Delegates the proper changes in the Constitution and By-laws to allow the various districts to nominate Councilor and Vice-Councilors at district meetings and to arrange for those who do not have district meetings to nominate their councilors and vice-councilors at a caucus at the House of Delegates meeting."

The motion was duly seconded, and explained as a prime move, required to be submitted again at the second meeting of the House of Delegates, Tuesday, May 4, 1964, which prime move was affirmed by the Speaker after which the Speaker put the motion and upon vote the motion carried.

Amend Chapter 5, Section 2 of the By-laws, which is on Page 16, by adding at the end of said section the following:

"The Nominating Committee shall nominate as Councilor and Vice-Councilor the members designated by a majority vote of the members present at the district meeting held next preceding the annual meeting of the State Society."

"In the event no such district meeting is held, then the Nominating Committee shall nominate as Councilor and Vice-Councilor for that district the members designated by a majority vote of the delegates from that district present at the Annual Society."

Mr. Speaker, the Constitution and By-laws Committee studied this matter very carefully over the past year and concluded that such a proposed change not be made, but as directed by this body, we put this before you today.

SPEAKER KOONCE: You heard this presentation.

DR. KOONCE: I move the recommendation be accepted.

(The motion was seconded.)

DR. BRUCE B. BLACKMON: Gentlemen, I am not trying to be nasty about this thing, but I can't understand why this would not be good for cur Society. We will have about five or six under the sign that says District 5 after a while, and we will right there elect a member of the Nominating Committee.

Now last fall, we had our district meeting, and at the 5th District, there were about a hundred physicians, and at that time we thought that we would like to elect our member of the Nominating Committee, or certainly recommend him, and our Councilor, and our Vice-Councilor.

This thing has been going through the process now for about two, three or four years, certainly three; and we have always been advised that it is not best for the Society, but we don't find out why. If there is good reason for it not to go through, I will certainly change my stand and try to go along with the thinking of the better brains in the organization. But in some way we just don't come up with that.

I quote from a letter from our good President, Dr. Raiford, in correspondence we had. First I wrote to Dr. Raiford "As regards the election of councilors and other members who represent the various districts by the district members rather than by the nominating committee and a small caucus held at the time of the House of Delegates meeting, this proposal was made to the House of Delegates last year in exactly the same fashion as did Dr. George Paschal make the report concerning scientific membership. We were told at that time that the scientific membership situation would be voted on at the coming session. The situation regarding the election of councilors by the district members was worded almost verbatim as was Dr. Paschal's situation concerning the scientific membership and this was done on purpose so that it could follow the same route as Dr. Paschal's efforts and is to be voted on in May of 1965.

"This matter has been brought before the group and before the Constitution committee on several previous occasions and for some reason we have always managed to get the run-around. We in Fifth District are not trying to dictate to other districts how they handle their problems, and if you will remember this was so worded that districts could continue to use the caucus if they so desired, but we in the Fifth District would like to do our election of these officers at our district meeting when there are usually as many as one hundred men present. We see no reason that this should create any burden on the State Medical Society and hope to see it go through in the proper order in May. If there is any logical reason that this will create a hardship or problem, we would be delighted to take it into consideration. If not, then we will expect to see it follow the same pattern as will the scientific membership proposal if it is voted on this year.

"Thank you again for what you are doing for organized medicine in North Carolina. I am sure you spent many hard and long hours with it this year. Thank you."

Now his reply, and if you will permit me, I will skip a couple of paragraphs that we have already covered today:

"Your motion made on the floor of the House of Delegates at Greensboro, May 3rd, and taken from the transaction as recorded reads as follows:"

And then it's just what you have heard read.

"I move that next year the Constitution and By-laws Committee present to this House of Delegates the proper changes in the Constitution and By-laws to allow the various districts to nominate Councilor and Vice-Councilors at district meetings and to arrange for those who do not have district meetings to nominate their councilors and vice-coucilors at a caucus at the House of Delegates meeting."

The motion was passed after a few remarks of clarification. My interpretation of this — and I am sure it concurs with Dr. McMillan's — that the Committee of Constitution and By-laws is authorized to bring before the House of Delegates a proposed amendment which would be presented to the House of Delegates for their approval or disapproval. If approved, it can then be ratified at the second meeting of the House of Delegates on the following Tuesday, since it involves a change in the By-laws and not the Constitution.

I met with the Committee in Pinehurst on February 6th and this is being done. It is not identical to George Paschal's motion since his spelled out the changes of the proposed amendments, whereas yours requested the committee to formulate an amendment.

Then I have one further item. Dr. Roscoe McMillan — a letter I sent to Dr. Mac. "I had a letter from Dr. Raiford who says that your Committee on Constitution and By-laws is working on an amendment to the By-laws which will allow for the handling of nomination of Councilors and Vice-Councilors on the district level. I would appreciate it if you would send me a copy of what you are proposing to present to the House of Delegates concerning this. I hope by doing this we can clear this matter and not take up a lot more time of the House of Delegates. As I have expressed before,

my only aim is to get the representatives in these positions who suit the will of most of the people, which would certainly be easier to ascertain at our local district meeting than it is at a caucus where there are five to eight present. Thank you again for what you are doing for organized medicine," and a story.

I did not get a reply to that letter at all, and only today I found out what the proposal is. Now if there is reason that this is bad for organized medicine in North Carolina, I am certainly willing to listen to it and would like to. If not, then I certainly have an opportunity to nominate our Councilors and our Vice-Councilors; and sir, if this would like to see the people in the Fifth District is the second and final reading, we would go along with that. If this is the first reading, I would like to know it.

SPEAKER REECE: This is the first reading. DR. BLACKMON: Then I would like to include an amendment to include the member of the Nominating Committee in with what Dr. McMillan has just presented. He is a representative of our District.

DR. McMILLAN: I agree with him on that. I didn't state the reason for it, because I thought Bruce was going to ask me about it a while ago. The reason I want to apologize about not giving an answer — I tried my best to get something worked out along this line all spring. We studied and we would write it, study it again and rewrite it, and we came up with nothing. We got up here yesterday afternoon, and we've been working on this thing ever since about six o'clock yesterday afternoon, except a few hours sleep last night.

Our reasons are these: That there are a good many districts in the State who do not have meetings, and those that have them often are not well attended by representatives from every component society in that district.

Next, each district is represented on the Nominating Comittee by a member of the district elected at caucus of delegates from that district. He is supposed to act for that district.

Third, if they are not satisfied with what the Nominating Committee does, the floor is always open for nominations in addition to the ones submitted by the Nominating Committee. And we have several other reasons, but those are the main ones, Mr. Speaker.

SPEAKER REECE: You have heard the recommendation.

A MEMBER: I don't understand why this isn't a second reading of this. This was brought up very explicitly last year, just as explicit as it was today.

SPEAKER REECE: The request, as I understand it — the request was made to prepare it for reading at this time. And the recommendation of the Committee is that it not be done.

The motion has been made that it not be done,

and it is seconded. Any further discussion concerning this?

DR. SHAFFNER: As a member of the Constitution and By-Laws Committee, I would like to give my remarks about the deliberation.

The delegates represent numerically 25 or a major fraction of the members of the Society. If a district votes for a member for a Councilor and Vice-Councilor, district meetings may not actually represent the various component societies in a numerical way as delegates represent component societies on a membership number basis. Furthermore, it is the feeling of the Constitution and By-Laws Committee that the Nominating Committee should consider any recommendations made to it by the district as to those who think they might be good delegates, good Councilors or Vice-Councilors; but it should also be the duty of the Nominating Committee to consider at length all aspects of such recommendations before it presents its nominations to the House of Delegates.

This would include consideration of the fact that not only does a Councilor represent his district to the Executive Council, as a member of the Executive Council who represents the State Society to the District Society, and therefore the proposed nominee would in effect or is in effect an administrative officer as a member of the Council in the State Society, and not just a representative of his district.

Therefore, the Constitution and By-Laws Committee feels that the Nominating Committee should have the prerogative of considering nominations to it, but not be limited in putting in nomination only those which might be recommended to it by a district meeting.

It is further the thinking of the Constitution and By-Laws Committee that those districts which do not have meetings to nominate or place before the Nominating Committee for Councilor — those who do not have district meetings, they in turn would have to have a caucus at a meeting like now, the first meeting of the House of Delegates of the year, which in turn would not allow the Nominating Committee to even consider in time this man's qualifications.

In view of the fact that the floor is open for other nominations, it would seem that the present setup would be more equitable in allowing representation in election of Councilors and Vice-Councilors.

SPEAKER REECE: Any further discussion?

DR. SHACKELFORD: The Committee on Constitution and By-Laws brought a recommendation to afford a By-Law change. Now they voted not in favor of this recommendation.

Now was the motion that was made to accept the report of the Committee, or to approve the change in the Constitution and By-Laws?

SPEAKER REECE: The Chair understands it is to accept the report of the Committee.

DR. KOONCE: My motion was to approve the recommendation of the Committee.

SPEAKER REECE: The recommendation of the Committee that it not be approved.

The motion has been made and seconded. All in favor say "aye"; opposed "no." The "ayes" have it; so carried.

SPEAKER REECE: We accept the recommendation, which was not to do it.

DR. BLACKMON: What can we do in the Fifth District next year? Can we in the Fifth District next year nominate a Councilor and a Vice-Councilor?

A MEMBER: You can from the floor.

SPEAKER REECE: Can you clarify this, Dr. McMillan?

DR. McMILLAN: State your question again.

DR. BLACKMON: I think we've got two negatives in here. We're voting against a negative. Now what can we do in the Fifth District next year?

DR. McMILLAN: You can recommend a Councilor and Vice-Councilor.

DR. RAIFORD: I think it's a little bit unclear in this respect. The Committee on Constitution and By-Laws was requested to bring to this meeting a proposed amendment — an amendment to the By-laws which would permit each district to nominate, not elect, its Councilor. What it means is simply this:

As Dr. Blackmon asked, what can they do next year? They can nominate through their representative to the Nominating Committee the person who they might wish to elect as Councilor. If their representative on the Nominating Committee does not see fit to put into nomination the individual they recommend, he has two methods of recourse. One is to elect a new member of the Nominating Committee who will convey their wishes. The other is to nominate a person from the floor.

Now as to clarifying the motion, Dr. McMillan brought before the House of Delegates the proposed change in amendments. He then stated that the committee recommended against this proposed change, and that is a recommendation that was voted on and passed; that this proposed change not be accepted.

Does that make it clear?

 $SPEAKER\ REECE$: We come now to item E, the report of the Commissioners.

Dr. Benton, do you have anything new?

DR. BENTON: I have been requested to make one additional report to the House from the Finance Committee.

We have in the past made arrangements for all of our employees to be able, at a certain age, to retire. At the time it was put in, it was not feasible to include our Executive Secretary.

As time went on, it became obvious that we had to do that, and we have now instituted machinery whereby if the Executive Secretary lives long enough, he can retire. That concludes my report.

SPEAKER REECE: That, of course, is published in the Compilation.

Advisory and Study Commission.

(No report)

Annual Convention Commission.

(No report)

Professional Service Commission, Dr. Lindsey.

DR. MARK M. LINDSEY: Mr. Speaker, one additional item has come up with the Committee on Nursing that I think the House of Delegates should be aware of.

At the time of the completion of the report, there had been several meetings of the Nurses Committee, particularly in reference to legislation. A letter has recently gone out to all of the doctors in counties who have schools of nursing, and the letter reads in brief to this effect:

"Your Committee, with the North Carolina Diploma Schools of Nursing, has sponsored a bill in the legislature, Senate Bill 305, which in effect would support monetarily the diploma schools of nursing. This is called on because of an extreme shortage of nursing, and because of the fact that 92 per cent of the bedside nurses in North Carolina are from diploma schools of nursing. Your attention is called to this item for your information."

No further report.

SPEAKER REECE: Public Relations Commission, Dr. Welton.

DR. WELTON: We have one additional report we would like to have the House hear, and I would like to call on Dr. Ed Beddingfield.

DR. BEDDINGFIELD: Mr. Speaker, members of the House of Delegates: This is a supplementary report from the Committee on Legislation in addition to that found in your Compilation.

I will try to make this very brief. First of all, at the national legislative scene, you have already heard some reference today to the status of the Omnibus Medicare Bill that was passed by the House of Representatives. It is now before the U. S. Senate. Hearings began this week in the Senate Finance Committee under Senator Harry Byrd. Hearings will probably be prolonged and drawn out — perhaps over several weeks.

The rules of the U. S. Senate being somewhat different from the rules of the House of Representatives, the course of this bill through the legislative mill in the Senate will be somewhat different than what it was in the House. The House of Representatives did not permit any amendments from the floor to the Medicare Bill. The Senate permits an unlimited number of amendments. It is virtually certain that amendments will be offered both by proponents and opponents of Medicare.

The overall strategy of medicine, with its interest in this omnibus medical bill — the interest is still being maintained. The strategy will be somewhat different. There will be no mass education campaign with television, radio; no massive letterwriting campaign. The strategy will be at the top

level with leaders in American medicine dealing with Senators who are sympathetic to medicine's point of view, and will take the form of various amendments that will be offered on the floor of the Senate. You will hear about those.

The proponents of Medicare will probably attempt to offer amendments to reinstitute the inclusion of the captive specialties, radiologists, pathologists, anesthesiologists, physiologists, back into Medicare. This was deleted by the House.

There may be some consideration to an attempt to delete Social Security coverage for self-employed physicians from the present bill. There may be some clarifying amendments regarding the part of the bill that has voluntary insurance for those of us 65 regarding the payments in negotiations — physicians' fees. That is reported simply as a point of information. We are following the developments very carefully.

At the level of State legislation, I wish you would take some notes on this, because things are breaking very rapidly in Raleigh, and we need your help urgently on certain bills. This has been a very active General Assembly. As of adjournment Friday, a total of 1,185 bills will be introduced; 365 in the Senate, 820 in the House; and approximately a hundred of these bills have received the close scrutiny of the Committee on Legislation and the headquarters staff.

At the present time, I give you a progress report on certain specific more important bills.

First of all, you will be interested to know that Senate Bill 210, which pertained to optometry, was enacted and is now the law of the State. We made an effort to oppose this bill; we made a very serious effort. The Committee on Legislation met with the Committee on Eye Care. We met with other interested groups, including representatives of Blue Cross, Blue Shield, both from Durham and Chapel Hill, and the representatives from the private health insurance industry, because this bill in effect said this: That any insurance plan, whether a Blue plan or whether a commercial health insurance plan, if it provided benefits optometrists were capable of providing, then they would have to be paid as well as ophthalmologists.

The last part of the bill pertained to state agencies providing eye care, such as the Blind Commission, the Welfare Department, and others, and simply said that a state agency that provided eye care could not discriminate between ophthalmologists and optometrists. That was already the law, as a matter of fact, based on statute and based on several rulings of the Attorney General.

So in summary this bill was simply a mild status-seeking bill for the optometrists. We don't think we have been hurt badly by it in medicine. We would rather it not have come up, but it has, and we lost, and it's now law.

Senate Bill 305, to which Dr. Mark Lindsey just

referred: He would very much like you to note the number of this bill, Senate Bill 305. This is sponsored by our group, by the Medical Society, and it is occasioned by the fact that we do have a tremendous shortage of nurses in North Carolina. I don't think anybody will dispute that. That some 92 per cent of our practicing bedside registered nurses have come from the three-year diploma schools operated by the hospitals. This is the only group of nurses that doesn't receive some form of state subsidy as of now. We have a decreasing number of these schools, because they are in financial difficulty. Many schools have closed. An effort to preserve this proven source of supply of nurses - there is some precedent for this in other states - we would like to see the State of North Carolina undertake to subsidize these existing schools to maintain the prudent source of supply.

This bill is now in the Senate. It will be referred to the Senate Committee on Health. Hearings have not yet been scheduled. We will appear and support the bill at those hearings.

The next bill in which you may be interested, Senate Bill 228, revises the Nurse Practice Act. The Board of Nursing throughout many months has submitted to us many versions of various drafts of what their proposal would be to revise the Nurse Practice Act in this General Assembly. In some of the earlier versions of the bill, there were provisions that we did not favor. There were provisions that we objected to.

Counsel and advice was sought by the Board of Nursing, and their attorney, and we were not reluctant to provide them with consultant advice.

By the time the bill was introduced, it carried nothing we could object to, and we supported the bill in hearings. The hearings have already been held, and I would hazard a guess that the bill will probably pass.

Senate Bill 341. This is another bill sponsored by the Medical Society. This has been discussed, I think, here before. This simply amends the Voluntary Sterilization Law to permit litigation of the vas deferens outside the hospital. Hearings on this bill have not yet been scheduled. This is requested by several of our members, by urologists, surgeons, and some others, who were doing sterilizations on the male with local anesthesia, accepted as an office procedure, and the law required that all sterilization procedures be done in a hospital licensed by the Medical Care Commission.

It soon became apparent that this requirement was actually a detriment to men who wanted to be voluntarily sterilized, because of their name on the operating room schedule, and nurses floating all around — it didn't work too well.

We have not heard of any male legislators that might oppose this; so we have good hopes for success.

House Bill 510 is very important, and I wish you

would carefully note remarks on this bill. House Bill 510 pertains to the practice of chiropractic in North Carolina. We vigorously oppose this bill. This would expand the definition of what chiropractic is. It would extend that definition to say that chiropractic is whatever is taught in schools of chiropractic, so that the curriculum committees of the chiropractic schools would then, in effect, be writing law as to what chiropractors could do in North Carolina.

Hearings on this bill are scheduled for this Thursday morning of next week before the Committee on Health of the House at nine o'clock. We will have a brief and some witnesses at that time. We would very much like for you to speak to your Representative in the House in particular, and particularly if your Representative is a member of the Judiciary Committee of the House, and urge him to vote against this bill.

House Bills 417 and 418, which are sponsored by the State Bureau of Investigation, relate to control of barbituate and amphetamine drugs. Our final analysis of these bills is not complete, but we now feel these bills will not prove burdensome to these physicians. We call attention to physicians that dispense their own drugs to this bill because there are some requirements for record-keeping in these bills. Hearings are not yet scheduled.

We will complete our analysis on that bill. As far as we know now, we do not see anything objectionable in it.

There are two matters pertaining to bills not yet introduced, but might very well be introduced. The first obtains to the licensure of psychologists. This is an old one. Of course, we are not opposed to psychologists. We think they are highly trained professional, very useful people. The only difference of opinion between the psychologist and medicine is in the definition of psychotherapy. They have a rather all-embracing definition, and we think that it takes in part of the practice of medicine. We would not oppose a certification or a licensure of psychologists, if it were properly amended, so that the practice of medicine in the realm of psychotherapy would not be infringed upon.

We have had several meetings with the psychologists and with legislators who would like to sponsor their legislation. The particular legislators we have talked to feel that our amendment is reasonable, and have urged the psychologists to accept it, and they will not accept it.

Now their problem is to find an introducer who will introduce the bill according to their version of it and then actively support it.

I would like to point out, because we have had many letters from physicians asking why we oppose the licensure of psychologists, this has been occasioned by a situation that arose here in the State in a particular city where an individual who was not trained at all set himself up in practice and said he was a psychologist. He paid a Schedule B

privilege license tax, which any individual can do, and he had a license stamp showing that he had paid the tax from the State, saying that John Doe has paid the license for psychologist. I could be licensed as a plumber or attorney, or anything else, by paying the required fee, but this doesn't give me a license to practice.

Because this happened in a particular city and this untrained individual set himself up, the Mental Health group in that city, and several physicians, and the Chief of Police, said "We now need a law to regulate the practice of psychology." Well, we don't at all, because this man would have been violating the Medical Practice Act. When that came to the attention of the medical people in that district, and at the state level, we turned this information over to the Board of Medical Examiners. They would have the State Board of Investigation investigate it. If they found out he was violating the Medical Practice Act, they would have turned the information over, and he would have been properly taken care of.

We have a mechanism already for untrained individuals practicing psychology, if this extends into the definition of the Medical Practice Act. That is no reason for us to favor the type of licensure act requested by psychologists.

So this is in limbo at the present time.

Finally, a mention about a proposed bill on osteopathy. Several legislators, and I might note some prominent and rather powerful legislators, have become interested in osteopathy and how it relates to the practice of medicine, and it is very likely that a bill will be introduced to create a commission to determine whether or not schools of osteopathy are teaching medicine in fact to the extent that graduates should be allowed to take the State Boards in medicine.

This wasn't our idea, and it wasn't generated from the State Medical Society; but we feel that it is hard to oppose a study. It's hard to pre-empt the findings of a study. So I will say that through the efforts of our attorney, we have been able to play some part in the drafting of the bill that proposes this study, and I judge that it will be introduced and will probably pass. I hope and have good reason to believe that doctors will have very good representation on this Study Commission, so that it can be studied from the standpoint of medical practitioners.

I have no further remarks to make, unless there are some questions. Thank you.

SPEAKER REECE: That completes the report of the Public Relations Commission.

The Public Service Commission.

(No report.)

Supplementary reports plus the material published in the Compilation are now ready for adoption. Do I hear a motion that they be adopted.

(Such motion was made, seconded, put to a vote and carried.)

We come now to the Committee on Nominations. I recognize Dr. Ted Raiford, our President, for the presentation.

DR. RAIFORD: Mr. Speaker and Delegates: One of the most difficult jobs of the entire year has been to assure myself that I wouldn't forget this, because according to the Constitutional regulation, this must be delivered to me at least two weeks beforehand. It was delivered some four weeks ago, and I was afraid that I might forget it, but I didn't.

As presented to me by the Chairman of the Committee on Nominations, Dr. William F. Hollister:

President-elect, Frank W. Jones, of Newton.

First Vice President, Walter Otis Duck of Mars Hill.

Second Vice President, John L. McCain of Wilson.

Constitutional Secretary for three-year term, Charles W. Styron.

Speaker of the House of Delegates, Dr. Donald B. Koonce of Wilmington.

Vice Speaker of the House, Dr. Robert L. Garrard of Greensboro.

Two elected members of the State Board of Health, Dr. Howard Steiger of Charlotte, Dr. Joseph Hiatt, Jr., of Pinehurst.

Two delegates to the American Medical Association for two-year term: Dr. Raiford and Dr. Johnson

Two alternate delegates to the American Medical Association for a two-year term, Dr. John S. Rhodes and Dr. Edgar T. Beddingfield.

Respectfully submitted, Dr. William F. Hollister, Chairman of the Nominating Committee.

SPEAKER REECE: You have heard the report of the Nominating Committee. Are there nominations to be presented from the floor?

DR. MILLARD HILL: Mr. Speaker, I hate to rise, but we are cutting our stature in the American Medical Association rather thin. We have two men who have just been there for only one year. We are going to have five-year stature with our four delegates. I am not opposed to Dr. Raiford, but I do feel that we need all the years we can get there, because the longer a man is there, the more he knows; the more he knows his way around, and the more people he knows, and the more he is able to give us good service.

And much as I hate to, I would like to place in nomination for re-election Dr. Elias Faison.

SPEAKER REECE: Dr. Elias Faison.

(The nomination was seconded.)

The Chair is going to take the authority to separate that one, and we will act on all the rest, unless there are other nominations from the floor. Are there other nominations from the floor?

DR. POTEAT: I move the adoption of the report, with the exception of the delegate to the American Medical Association.

(The motion was seconded.)

SPEAKER REECE: Motion has been made and seconded, we accept the report of the Nominating Committee. All in favor say "aye"; opposed "no." So carried.

PRESIDENT RAIFORD: I would like to say I agree with Dr. Hill a hundred per cent. I feel we need age and experience in the House of Delegates to the American Medical Association, and accordingly I would like to withdraw my name from nomination.

DR. SAMS: I move you, sir, that we accept his withdrawal, and that we elect Dr. Faison by acclamation, and Dr. Johnson.

(The motion was accepted.)

SPEAKER REECE: The motion has been made to accept this. All in favor say "aye"; opposed? So carried.

DR. KOONCE: Mr. Speaker, might I say that is an extremely gracious thing to do.

DR. POTEAT: Mr. Speaker, I now move the election of Drs. Johnson and Faison as delegates to the American Medical Association.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: We come now to nominations from the floor for the election of trustees: Number 1, in the Hospital Saving Association. Dr. Hart's term expires.

Do we have a nomination from the floor for this position?

A MEMBER: I would like to nominate Dr. Hart. DR. WELTON: Does this pertain to Hospital Saving Association?

SPEAKER REECE: Yes.

DR. WELTON: I would like to place in nomination the name of D. K. Hart.

SPEAKER REECE: It's already been presented. (The motion was seconded by Dr. McMillan.)

SPEAKER REECE: Are there any other nominations for this position?

DR. JOHNSON: I move nominations be closed and Dr. Hart be elected by acclamation.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: Hospital Care Association, Dr. Wilkinson's term expires. Are there nominations.

DR. RHODES: I would like to place in nomination the name of Dr. T. C. Wilkinson.

(The nomination was seconded by Dr. Ward.)

DR. SAMS: I move that nominations be closed and Dr. Wilkinson be elected by acclamation.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: Medical Care Commission, Dr. Brewer's term expires.

DR. KERNODLE: Mr. Speaker, I would like to place in nomination Dr. Brewer for an additional term on the Medical Care Commission.

(The nomination was seconded.)

SPEAKER REECE: Motion made and seconded. Are there any other nominations?

(A motion was made that nominations be closed and Dr. Brewer elected by acclamation; motion seconded, put to a vote and carried.)

SPEAKER REECE: Retirement Saving Plan.

DR. CALDWELL: Mr. Speaker, I wish to nominate and move the re-election of those committee members whose terms have expired, Dr. Wayne Benton and Dr. Robert Williams.

SPEAKER REECE: Motion has been made.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: Report of the Committee on Grievances. We do not have a report.

Committee on Negotiations, Dr. Hollister.

DR. HOLLISTER: I have no further report, Mr. Chairman.

SPEAKER REECE: Do I hear a motion that we adopt the report of the Committee on Negotiations?

(Such motion was made, seconded, put to a vote and carried.)

We will recognize our President for the report of the Executive Council.

PRESIDENT RAIFORD: I offer as a report of the Executive Council the abridged summary of the interim actions of the Executive Council as of September 27, 1964, and February 7, 1965.

I would like particularly to call your attention to the Treasurer's report and the budget, which has been accepted and recommended to you through the medium of this abridged version.

The rest of the report I think is adequately self-explanatory. There is one item which is not included in this, inasmuch as it transpired during the executive session of the Executive Council. I would ask Dr. Benton if he would report on this particular area.

DR. BENTON: I just did that a little while ago, unless you want me to say the exact figures.

PRESIDENT RAIFORD: I do not think it is necessary to repeat it; however, it should be included in the motion to accept this report, and that is why I ask you if you want to elaborate on it or offer your former comments as the report.

DR. BENTON: Well, the Constitution and By-Laws require that the Finance Committee report to the House of Delegates, and it requires that we have an audit made of our funds, which has been done, and it is in the Compilation. It shows that we are in good financial shape, and that we made more money last year than we spent. It further requires that we formulate a budget for next year. That has been done, and it is in effect, and the budget is set up so that our income will be more than our expenditures.

And the third thing it requires is to make a recommendation as to salaries and the business of the headquarters office. We had in the past set up machinery, mechanism whereby all of our employees could eventually retire with salary. At that time, it was not feasible for good reason to put the Executive Secretary in there, and he was not included in this. But it became evident that we needed to have this, and it has been — the mechanism has been set up and is in effect; and it costs us a little bit more than it would have to have had it in longer, but it's still good business, and we're getting out cheaper than the average state medical society, and I don't mean that our Executive Secretary is cheap.

PRESIDENT RAIFORD: I think that adequately explains it, unless there is some question that a member of the House of Delegates would like to place to you. If not, I would offer the abridged report by the House of Delegates, and I so move, Mr. Speaker.

SPEAKER REECE: You have heard the motion. Is there a second to it?

(The motion was seconded, put to a vote and carried.)

We come now to Item G, Consideration of statewide billing of county society dues combined with authorized billing of State and AMA dues.

Dr. Kernodle is to speak to this.

DR. KERNODLE: Mr. Speaker, President Raiford, members of the House of Delegates, Ladies and Gentlemen:

I was asked to present this program. The House last year recommended and passed a change in the By-laws suggesting central billing. The Executive Committee has taken action upon this and is now planning on implementing central billing January 1, 1966, with certain reservations.

Each county will be solicited as to their desire to have the billing for dues for the county collected by the State Executive Director in Raleigh, and then the dues would be sent back, county dues will be sent back to the local counties. Immediately some people say this is taking things out of the hands of the county society.

I point out to you that there have been many delays in collection of dues. Some of the larger societies have excellent secretaries, and paid secretaries, that do this work; and others are collecting dues from their members from April through May, and sometimes don't even get the dues in in time for this meeting; so that the delegates can be elected to attend.

Because of this difference of handling of monies by doctors, it has been recommended and decided upon to start central billing. Each county will be advised of this and asked if they want to participate, or if they want to continue as they have been doing in the past.

The point that I rise to bring to you is the idea of adding to this central billing a contribution for MEDPAC of North Carolina, and AMPAC. Now, why do we bring this to you as a House of Dele-

gates action? First, we attempted to discuss this last year in the same House of Delegates in Greensboro, and there was some difference of opinion and misunderstanding. At this time, I would like to say a few words of what MEDPAC and AMPAC is doing, and plans to do in the future.

This is a political action committee of our State, and the American Medical Association's. It is a function that I feel is most important. We have had a terrific blow in Washington. The blow occurred last November 3rd. Immediately thereafter, our Congressmen who were left in Washington started running again for a two-year election, November 8, 1966.

There are many of our friends in Washington that are running scared right now. We have been asked to help them in many ways, financially; help them with their educational programs; help them with the research of what is going on in their district; help them with the volunteer workers on the precinct and district levels.

With this in mind, it has been found that we need a considerable amount of monies, monies to help them do these educational programs, monies to help them in the actual downright payment of financing.

It has also been found that the AMPAC program has developed very rapidly in the states that have made assessments of each of their members for dues on the state and national level. There are some 15 states that have already done this. They have a central billing program in which they are collecting from \$20 to \$50 for political action. California, Illinois and a few others have had this for sometime. They have increased the amount of money.

What we want to do in North Carolina is this: We want to put on the statement that is going to be sent out from the central office — and it will have the state dues, the AMA dues, and any other dues that will be necessary to put on that statement; but also we are recommending, and recommended by the Finance Committee, adopted unanimously by the Executive Council yesterday, and first adopted last February, on February 7th, and then again reiterated yesterday afternoon.

The form would be in this manner, because a lot of people say maybe we do want to contribute, and maybe we don't want to contribute to programs of a political nature.

This is an IBM card, and it gives a listing. It says AMPAC, MEDPAC, the dues at the top, Bucks County Medical Society, building fund, scholarship assessment, and all of these are entered, and then a total.

We in this group — I might state the AMPAC-MEDPAC has an asterisk beside it, and it says it is a voluntary contribution, and it is not tax deductible. We have discussed this. We feel that this is the way to handle this business, and we feel that we are in this business up to our ears, and if we

don't watch out, we're going to sink all the way down. It's very, very important that we in medicine wake up.

We in North Carolina — the Council felt that it would be wise to total these things other than AMPAC and MEDPAC, and then put the AMPAC and MEDPAC in a line under that, and then you would have a second total. There would be no question of what you were paying or why you were paying it.

I would like to tell you a few things as to why, further, we need this money. Just this week, your Legislative Chairman told you that the optometry bill passed, and it passed without any problems. In fact, they were 'way, 'way over the numbers that they needed to pass that bill.

The optometrists in North Carolina for a number of years — six or more that I know of — are paying \$1,500 a year assessment for political action, per member, per year.

Unions throughout are charging anywhere from \$5 to \$50 per month for their membership in political action. We in medicine have taken a very definite beating in Washington. If we want to stop any of these actions up there, we're going to need to wake up and take an interest in it.

I would like to report to you what has happened in Washington with our own Congressmen, and why we should be proud to have a little part in sending some of them back up there, if not a great part.

The North Carolina Congressional delegation as a whole voted solid on the amendment to recommit the Medicare Omnibus Bill. Now some of you think that our delegation voted for Medicare and did not follow our dictums. Well, perhaps if you look at the whole Omnibus Bill, it's true they did not all vote that way; but the crucial point that they voted against was Medicare, when they voted to resubmit the bill, and in many of the papers in North Carolina there was nothing said about this amendment vote. It was 236 to 191. The 191 vote is the largest vote against anything that the Administration has desired in this Congress. It is the first time they have been able to get together and get those people in a conservative mood to vote together, both Republicans and Democrats.

North Carolina's complete delegation voted for that amendment. Therefore, I can tell you that we in North Carolina are fortunate, because we are served by people that see our way.

Now you say why didn't they vote the second time around? Well, in some instances they called some of the doctors in their districts, and they were given releases, and they were allowed to vote the second way as they saw fit. And some of them felt it was like voting to beat your mother if you didn't vote for that omnibus part, the second part of the bill. A few others stuck with us and stayed down the line.

But I think that we should be appreciative of what they have done with regard to Medicare. I can tell you that our two Senators are very much opposed to the Medicare program. The likelihood of striking out Medicare at the present time — there are three, or four, or maybe six amendments that would be put into the box. One of those will involve many of you here, you specialists that work in hospitals, anesthesiologists, radiologists, and the like. There is a feeling that this will be stricken from the bill when it comes from the Finance Committee.

They are asking us, and I say they are asking us, AMPAC on the national level, to give them support right now for education, for research programs in their own districts, and they have already indicated they are going to ask us for a lot of money from the standpoint of their candidates' support for the 1966 election.

We need these funds. We have found in the State of Pennsylvania, where this is being carried out, that some 90 per cent of the doctors participated, because they had an opportunity to see this all in one. Some say this is coercion. I don't think so. I think they are realistic up there.

In Illinois, and in California, they have added as an assessment — every member is required to pay so much toward the political action program. In three other states last week, they added the same type of program of central billing and direct billing on a voluntary basis, namely, Iowa, Florida, and Arizona.

I plead with you for the good of medicine, and far the ability to get ourselves involved deeper into politics where we will have to be if we are to control any of this program in Washington, to accept the motion that I make at this moment.

The motion is that we include in the central billing form to be sent to our members on January 1st a voluntary contribution for AMPAC-MEDPAC of North Carolina of \$20, and that this be identified as a voluntary contribution, non-tax deductible.

Thank you.

SPEAKER REECE: You have heard the presentation. Is there any discussion of the motion?

(The motion was seconded by Dr. Poteat.)

DR. CHAPMAN (Buncombe): In writing medical papers, one of the things we are always taught is to try to be intellectually honest. When we include in our Medical Society dues any other dues, regardless of what fine purpose they may be for, it seems to me that we can be accused at least of not being intellectually honest.

If we want to send out with our state bill a bill for AMPAC, then I think that rests with the Executive Council; but I do not think we should be taking advantage of the stupidity of those of us who don't read all the bills we get, as certain City Directory people have done, and send out a bill for something that is not state dues.

If we vote an assessment for the Medical Society for political action, then I would be very much in favor of supporting it. But I am not in favor of supporting any other organization, no matter how fine it may be, with the Medical Society billhead on top of it.

I am in hopes that my own county society will not go along with central billing of county society dues, because I think this is something that should be kept within the control of the county. And I hope you will be intellectually honest when you vote on this question.

SPEAKER REECE: Further discussion?

DR. JONES (Ashe): I don't believe the physicians in my county will want to be billed for this. I think most of them will want to give to it, but I don't think they want it to be made a thing voted on by the Medical Society. I don't think the Medical Society should become a pressure group, just like the labor unions. I give to this political action thing myself. I'm willing to give. But I am certainly not willing to have it put on me as a dues from the State Medical Society, and I'm sure that the men in my county would not want it that way.

DR. RHODES: I have one or two comments to make in support of the motion that Dr. Kernodle has explained quite effectively, it seems to me, to this group.

Whether we like it or not, we are being pressured, and because we're losing a retreating battle doesn't mean that we should give up at this point and surrender.

If we are apathetic, and we have been too apathetic in the past, if we do not make ourselves aware of the political facts of life, if we do not support as an organization the precepts of the private free practice of medicine, then we are going down to defeat.

Apathy will not save us, and we are not here pressuring anyone to pay dues to AMPAC or MEDPAC. We are simply making it convenient for the members of our organization to take a part in this activity, if they so wish.

I would be seech you to consider this favorably, because I believe it is the one mechanism by which we can support the freedom of the practice of medicine. I ask you to vote for this motion.

SPEAKER REECE: Further discussion? Are you ready for the question? All in favor that central billing be taken care of, AMPAC and MEDPAC, from our Raleigh office say "aye"; opposed "no." The "ayes" have it.

We will now recess for the organization of the Nominating Committee.

(Recess)

SPEAKER REECE: The Secretary will now read the names of the new Nominating Committee and give them their instructions.

DR. STYRON: Immediately your names are read, I wish that the nominee for the Nominating Com-

mittee would come through this door and gather at the end of this hall for the purpose of electing a chairman.

The following have been nominated from the various districts: Dr. John Payne, E. W. Ferguson, J. W. Nance, R. M. Whitley, Bruce Blackmon, Kempton Jones, Vernon Andrews, John Burwell, Harvey Robertson and John Hoskins.

SPEAKER REECE: These are the nominees. Do I hear a motion?

DR. WARD: I move they be accepted.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: We will make the announcement now that we can complete the transaction of our business this afternoon, and we will not have to have a meeting of the House of Delegates tomorrow, Monday.

The next meeting of the House of Delegates will be 2:30 p.m., on Tuesday, May 4th.

We do have a resolution that was presented and has been circularized to you. Dr. Johnson, do you wish to speak to this resolution?

I think you all have copies of this resolution. This will be referred to the Committee on Resolutions, the Reference Committee, and they will report back at the Tuesday afternoon session.

PRESIDENT RAIFORD: Mr. Speaker, may I say that this resolution was presented yesterday before the Executive Council, and by vote of the Executive Council, it instructed and recommended that this resolution be lodged with the House of Delegates, which does comply with the Constitution and By-laws on new resolutions, and it is proper for the Speaker to refer it to the Reference Committee for study and report on Tuesday.

SPEAKER REECE: So this resolution will be referred to the Reference Committee. Dr. Benton is chairman.

I hereby recognize Dr. Simons Patrick. Dr. Patrick has a resolution that I think we will have to get permission of the House to present it, but it is a non-controversial thing, and I would ask him to read it.

DR. PATRICK: Mr. Speaker, do I first have to have the permission of the House to read it?

SPEAKER REECE: You may read it.

DR. PATRICK: This is in reference to the socalled captive specialist. You have heard something of it this afternoon. Drs. Beddingfield and Raiford have mentioned it. This is the stand of the AMA and it is also the thoughts and the recommendations of the American College of Pathologists, the American College of Radiology, the group of anesthesia, and the Psychiatrists.

The bill as passed by the House of Representatives of the U. S. Congress provides that the professional services of the pathologists, radiologists, anesthesiologists, and the psychiatrists, be included in the optional portion of the bill to provide for professional services, and not as hospi-

tal services, and whereas there is a concentrated effort being made in the U. S. Senate to mend the bill so as to return the above-mentioned professional services to hospital services, be it

RESOLVED, that the House of Delegates of the North Carolina Medical Society go on record with our Senators that the services of the pathologist, the radiologist, anesthesiologist and the psychiatrist be kept in the category of professional services; be it further

RESOLVED, that this action in no way indicates endorsement of the Medicare bill before Congress.

This is a request for this House of Delegates to endorse the principles which the AMA and the various specialty groups have in reference to the category in which these men are included in this bill.

SPEAKER REECE: As I understand it, this resolution is in keeping with the spirit of many of the reports presented this afternoon. If the House is to act on it, I must ask for permission of the House for you to accept this, so that it can be referred to a Reference Committee. It will require a two-thirds vote.

DR. KOONCE: I move it be referred to the Reference Committee.

(The motion was seconded by Dr. Ward.)

SPEAKER REECE: Motion made and seconded that we refer this to a Reference Committee. All in favor say "aye"; opposed "no." So carried. That will also be referred to the Reference Committee.

MR. BARNES: You are ruling that there was a two-thirds vote?

SPEAKER REECE: Yes.

Any other unfinished business?

Mr. President, do you have any new business to bring up, or any comments you wish to make?

PRESIDENT RAIFORD: No.

DR. BURWELL: We have taken some very decisive actions here today. I do not think we should allow this occasion pass without expressing our deep and sincere gratitude for the services he has rendered these past ten years, and I would like to move you, sir, that we give him a rising vote of thanks.

(The delegates rose and applauded.)

DR. SAMS: I think we should reiterate that to Dr. Brewer and the other member of the committee too, because that has been a very loyal committee to the State Medical Society.

SPEAKER REECE: Thank you, Dr. Sams, for your remark.

Any other business to come before the house?

If not, may I express to you my sincere appreciation for the attention and the dispatch with which you have conducted your business this afternoon. Do I hear a motion that we adjourn?

(Such motion was made, seconded, put to a vote and carried, at which point the meeting adjourned at five forty-five o'clock.)

TUESDAY AFTERNOON SESSION May 4, 1965

The Second Meeting of the House of Delegates convened at two-forty p.m., Dr. John C. Reece, Speaker of the House, presiding.

PRESIDENT THEODORE RAIFORD: I will declare the second meeting of the Medical Society of North Carolina in session. I will now recognize Dr. John C. Reece, Speaker.

SPEAKER REECE: Mr. President, we have only a few items of business to take up this afternoon, so we should not be detaining you for a long period of time.

The first item we will take up under unfinished business is final ratification of the By-Laws, the second reading of the amendments introduced at the first meeting, May 2, 1965. I recognize Dr. Roscoe McMillan.

DR. ROSCOE McMILLAN: Mr. Speaker, Mr. President, members of the House of Delegates: Changes first in the By-laws, item 2, Amend Chapter 10, Section 16 of the By-Laws by inserting in line 1, page 34, after the words "Doctors' Plan" the following:

"... and to advise and counsel concerning matters related to Blue Cross, indemnity coverage, extended benefits and major medical coverage administered by Hospital Saving Association and Hospital Care Association, as requested," —

This change was brought about by the fact that a Committee on Blue Shield over the past eighteen years has been called upon to confer, consult, and advise the two associations in respect to the medical aspects of administration of their respective indemnity insurance programs, and it was the sense of the Committee and the Executive Council that this should be an authorized function of the Committee.

I move, Mr. Speaker, the adoption of this change. SPEAKER REECE: You have heard the motion. Is there a second?

(The motion was seconded, put to a vote and carried.)

DR. McMILLAN: Amend Chapter 10, Section 19, by deleting the words "except the Committee on Nominations and Committee on Grievances," and substituting in lieu thereof: "except as otherwise provided."

I move the adoption of this amendment.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: Proceed.

DR. McMILLAN: Now, Mr. Speaker, I go back to the Constitution, which was presented last year in Greensboro to be voted on this time. I really don't think this has to be voted on again. It was carried Sunday afternoon. However, in view of the fact that there might be a little controversy, I would appreciate the House of Delegates voting again today. I am going to read it to you.

Amend Article IV, Section 2 of the Constitution, page 2, by inserting between the words "the members" the word "active." The Section will then read:

"Active members of this Society shall be the active members of the component societies, and those physicians who are admitted by the Executive Council as hereinafter provided."

I move the adoption of this.

(The motion was seconded, put to a vote and carried.)

DR. McMILLAN: Now, Mr. Speaker, we passed on Sunday afternoon to admit the Negroes for full membership. I am a little bit disturbed in my own mind whether we should not carry this through to amend Chapter XV, Section 5 of the By-Laws, and I am going to read them to you and see for sure. I want this absolutely correct.

Amend Chapter XV, Section 5 of the By-Laws on page 39 by adding this new sentence after the word "members":

"A county society may admit other members upon such basis or classification as it may determine."

The section will then read:

"Each county society shall be the judge of the qualifications of its own members, but, as such societies are the portals to this Society and to the American Medical Association, only reputable and legally registered physicians who are practicing, or who will agree to practice, non-sectarian medicine, shall be admitted as active members. A county society may admit other members upon such basis or classification as it may determine."

I'd like to have a ruling, Mr. Speaker.

MR. ANDERSON: It should be voted on. That was presented Sunday. It should be voted on today together with the rest of it.

SPEAKER REECE: You have heard the reading of this. Is there a motion?

DR. SAMS: I move the adoption, Mr. Speaker, of the changes in the By-Laws.

(The motion was seconded.)

SPEAKER REECE: Motion has been made and seconded. Any discussion?

DR. BENTON: In view of the fact that the chiropractic bill is coming up, and they have something in there to make the word physician legal in their bills coming up, should you not tie down the word "physician" in there to mean M.D. physician, or quoted from the dictionary what the word physician means, so that if the chiropractors become physicians also, then in their Constitution and By-Laws, they would be physicians. I am just asking a question.

DR. RHODES: The word non-sectarian takes care of it.

SPEAKER REECE: You have heard the motion and it has been seconded. All in favor say "aye"; opposed "No." So carried.

DR. McMILLAN: Amend Chapter IV, Section 11

of the By-Laws on page 14 by deleting the present section and inserting the reworded section to read as follows:

"The House of Delegates shall have authority through the Executive Council, by majority vote of the Council, a quorum being present, to elect to membership any reputable and legally registered physician who applies directly to the Society for membership as provided in Article IV of the Constitution, when such physician has been definitely refused admission to a local society and he has appealed to the Executive Council for membership and where, after hearing, the Council is convinced that such physician is eligible for membership in the State Society and that it is impossible to reconcile the local society to admitting him. The Executive Council shall certify the election of such physician to the Secretary. A member so elected shall, on payment of annual dues and assessments for the current year, be entitled to the rights and privileges of membership as provided by Article IV of the Constitution."

The wording changes from the old section include

A. Changing of the phrase "to elect any physician" to the phrase "to elect to membership any reputable and legally registered physician." This conforms to the wording of Chapter XV, Section 5.

B. By striking out the words "Section 4" in front of the words "Article IV." Those words are not appropriate, since they would refer and limit this section to affiliate members only.

C. Striking out the words "such physician has been unjustly refused membership in the local society," and inserting in lieu thereof the words "such physician is eligible for membership in the State Society." This change thereby removes any implied censure of a county society for being judge of the qualifications of its members.

A MEMBER: Should you clarify annual dues? That just means state dues — —

DR. McMILLAN: Yes.

I move the adoption.

(The motion was seconded, put to a vote and carried.)

DR. McMILLAN: I think that ends my report, Mr. Speaker.

SPEAKER REECE: The next item of business is a report to review the two messages of the President.

DR. J. S. RAPER: Mr. Speaker, Delegates:

Lord Bacon once remarked that each man owes to the profession which nourishes him some time and effort. Dr. Raiford has been called upon by us to give extraordinary time and effort in the affairs of our profession.

In his official words to this society, he has mentioned only briefly the constant day-to-day work of his administration. His thoughtful and critical analysis of the time honored methods of conducting

the affairs of this society has led to innovations which will aid in relieving tedious hours of council, preserve our democratic process and expedite the business of the society with no loss of communications.

We wish to commend Dr. Theodore S. Raiford for his thoughtful declarations of our past, present, and future role in the world in which we live.

(Applause)

SPEAKER REECE: You have heard the report of the Committee to review the two messages. Do I hear a motion that we adopt this?

(Such motion was made, seconded, put to a vote and carried.)

Congratulations, Dr. Raiford.

PRESIDENT RAIFORD: Thank you, John, and thank you all.

I now recognize Dr. Wayne Benton, Chairman of the Reference Committee.

DR. BENTON: Your Reference Committee on Resolutions met at 9:00 p.m. Sunday in the Queen Charlotte Hotel. A quorum of the Committee were present. Several speakers presented facts favoring the two items referred to the Committee. There were none speaking against them.

The first resolution considered was presented by the North Carolina Radiology Society and its purpose was simply to concur in the action taken by the AMA and specialists groups concerned urging Senator Jordan and Sentaor Erwin not to amend S. 1 - H. 1 "Medicare Bill" placing the services of pathologists, anesthesiologists, radiologists, and doctors practicing physican medicine under hospital services, but to let it remain in the optional portion of the bill under professional services as passed by the House. Our friends, the American Hospital Association, is backing this change but responsible medical groups are opposing it.

The resolve portion of the resolution reads as follows:

BE IT RESOLVED, that the House of Delegates of the Medical Society of the State of North Carolina urges our sentaors that the services of pathologists, radiologists, anesthesiologists, and doctors practicing physican medicine be kept in the category of professional services.

BE IT FURTHER RESOLVED, that this action in no way indicates endorsement of the "Medicare" bill before Congress.

Mr. Speaker, I move its adoption.

(The motion was seconded, put to a vote and carried.)

The next resolution considered was sponsored by Sampson County Medical Society and concerns establishing a long range planning committee by the American Medical Association. The following comments were repeatedly heard: "Worthy purpose," "I'm sure we need it," "I've read this resolution three times and now I'm convinced it's good," "I feel that this is good and we need a similar committee on the state level."

The resolve portion reads as follows:

BE IT RESOLVED, that there be established within the American Medical Association a permanent advisory committee on study policy, and planning, whose duty it is to study economic, philosophical, political, social and scientific trends of the day at hand as they bear upon public health, medical practice and medical care, with consideration of the effects which these may have upon the public and upon the medical profession and to advise the House of Delegates and the Board of Trustees of AMA as to projected policies and programs, and be it further

RESOLVED, that this committee be composed of nine members of the American Medical Association to be appointed jointly by the Speaker of the House of Delegates, the Chairman of the Board of Trustees, and the President of the American Medical Association, for terms of three years each, such terms to be staggered, and be it further

RESOLVED, that this committee shall submit a report to the House of Delegates of the AMA at each regular session and to the Board of Trustees at any regular meeting.

Your Committee approves this resolution.

Mr. Speaker, I move its adoption.

(The motion was duly seconded.)

SPEAKER REECE: Is there any discussion of this?

Dr. Johnson, since you helped originate this, we thought you might like to speak to it.

DR. JOHNSON: I don't care to take up a great deal of time in speaking to this resolution. I am sure that it will get considerable support on the floor of the House of Delegates of the American Medical Association.

No later than this noon, while associating with immediate past president of the American Medical Association, I heard expressions of thought, well, as a matter of fact I can quote — I was given the privilege of quoting some of the things that Ed Annis said, and he is concerned immensely about this area of policy-making within the American Medical Association's leadership.

So I think that there are those other than those of us in North Carolina, who are concerned about this, and if I may be allowed to, I would like to make a motion that if this House of Delegates sees fit to pass the recommendation of the Reference Committee, which you have just heard, that our Executive Director be authorized to send a copy of this resolution with action taken by the House of Delegates of the North Carolina State Medical Society, to every member of the House of Delegates of the American Medical Association, and that this be done in the immediate future, in order that others might be acquainted with the action taken by this state.

I make that in the form of a motion.

SPEAKER REECE: Would you like to make that as an amendment?

DR. JOHNSON: If I make it as an amendment to the resolution, it would all be voted on at the same time, and it would be more expeditious.

MR. BARNES: May I just suggest to Dr. Johnson, in the event that this motion prevails, this amendment prevails, it is customary if you send a resolution to the delegates, that you should also send it to the officers of the State association. Maybe you want to consider that.

DR. JOHNSON: I was not entirely familiar with the technique of communicating with the other states about matters such as this, and I will also alter the amendment and include that in the amendment to the motion which now stands.

SPEAKER REECE: Do I hear a second to this? (The motion was seconded.)

SPEAKER REECE: You have heard the reading of the motion, and the comments and the amendment by Dr. Johnson.

Any further discussion?

DR. BENTON: I want to correct an error. It is now called Omnibus Bill. . . .

A MEMBER: I wonder whether the AMA meets at regular session and interim session? This reads at regular session. Did you mean for it to come —

DR. JOHNSON: At each of the two sessions each year — why don't we say at all sessions of the House of Delegates?

DR. BENTON: The idea is that we approve of it and not so much the mechanism of it.

SPEAKER REECE: Any further discussion?

A MEMBER: We vote first on the amendment and then the main question.

SPEAKER REECE: The amendment was added to it and accepted.

DR. KERNODLE: For one thing of clarification, you are putting two programs in there, so I think if you're going to vote this as an amendment, the letter — I think if you take the amendment, and he withdraws this second amendment, and pass the resolution first, and then get the other one on the floor, we would be better off, because all of this would be in one resolution to go to the AMA, which is the mechanics.

DR. JOHNSON: We don't want that.

I stand corrected for a second time. The original motion that I made I will make — I withdraw all amendments and the floor is now open for passage of the resolution as it stands.

SPEAKER REECE: You have heard the resolution read. The motion has been made and seconded. All in favor say "aye"; opposed "no." So carried.

DR. BENTON: Mr. Speaker, I move the adoption of the report of the Reference Committee as a whole.

(The motion was seconded, put to a vote and carried.)

DR. JOHNSON: Now, Mr. Speaker, I make a motion to instruct the Executive Director of the Medical Society of the State of North Carolina to send copies of this resolution with explanatory

notes that it was passed unanimously by the House of Delegates at the North Carolina State Medical Society annual meeting, and that this be sent to each delegate of the AMA, and to the officers of the component state associations of the AMA.

I move that this be done.

SPEAKER REECE: Do I hear a second?

(The motion was seconded, put to a vote and carried.)

DR. PASCHAL: I would ask that the resolution he is speaking to be clarified. He says "this resolution." I assume he means the last one.

DR. JOHNSON: That's right.

DR. PASCHAL: I think it ought to be clear. SPEAKER REECE: This is the last resolution we were voting on.

Could we have any new business to come before the House, Mr. Secretary?

PRESIDENT RAIFORD: I rise to report a telegram received yesterday morning which I must apologize for having left in the room at my hotel. We received a telegram from Dr. Hubert Eaton of Wilmington expressing the satisfaction and commendation of the Old North State Medical Society for the action taken on Sunday.

I will see that this is recorded or placed in the hands of the recorder and duly recorded with the transactions of this meeting.

SPEAKER REECE: Thank you, Mr. President. Do we have any new business to come before the House?

DR. PASCHAL: Mr. Speaker, may I have a moment?

Mr. Speaker and fellow delegates: For the past 15 years, almost 15 years, we have had a continuing problem as related to something that was settled here at this particular session of the House of Delegates. This has been handled largely by our

Committee on Race Relations, the original committee composed of Dr. Street Brewer, Dr. Paul Whitaker and Dr. Ben Royal.

During these years, they and additional members of the committee have worked long, hard, tedious hours, and have given unstinted, dedicated service to the Medical Society and to the people of North Carolina.

For this, I would like to ask this House of Delegates at this time support an expression of profound appreciation for the services these men have given to this Society.

I move that this be done.

(The motion was seconded, put to a vote and carried.)

SPEAKER REECE: Any discussion further?

Mr. Secretary, do you have any more business before the House?

DR. STYRON: No, sir.

MR. BARNES: No, sir.

SPEAKER REECE: Does anyone have any new business to bring before the House of Delegates before we adjourn?

DR. KERNODLE: I think we ought to go on record thanking the Mecklenburg County Medical Society for the entertainment activities and social activities that they have given us at this meeting.

(Such motion was made, seconded, put to a vote and carried.) (Applause)

DR. SAMS: Why not add to that motion our thanks to the Ladies Auxiliary of the Mecklenburg Medical Society, the Academy of General Practice, and all connected with the welfare of the State Medical Society while in Charlotte. I'd like to make that motion.

SPEAKER REECE: It will be done.

(The meeting adjourned sine die at three-five o'clock.)

Report of the General Sessions

FIRST GENERAL SESSION CHARLOTTE, NORTH CAROLINA

Monday, May 3, 1965

The meeting was held in the Merchandise Mart, Charlotte, North Carolina, at 9:15 a.m., Dr. Theodore S. Raiford, President of the Medical Society of the State of North Carolina, presiding.

PRESIDENT RAIFORD: Ladies and gentlemen, it is now my privilege to convene the First General Session of the 111th Annual Meeting of the Medical Society of the State of North Carolina.

I will recognize Father Francis J. Tait of Our Lady of the Assumption Church of Charlotte for the invocation.

(Father Tait gave the invocation.)

PRESIDENT RAIFORD: Before the scientific part of the program is started, I have a couple of announcements and observations. The film that has just been shown is available for any section, group, or county medical society who might wish to use it. It is obtainable through our Public Relations Department through the headquarters office in Raleigh from the American Medical Association.

(Announcements.)

I would now like to introduce the first speaker on the morning program, which is in regard to Diagnosis and Management of Urinary Tract Infection, Dr. William J. DeMaria of the Department of Pediatrics, Duke Hospital, Durham.

(Dr. DeMaria's presentation has been submitted to the North Carolina Medical Journal for editorial disposition.)

(Applause)

PRESIDENT RAIFORD: Thank you, Dr. De-

I would introduce the next speaker as Dr. Janet Fischer of North Carolina Memorial Hospital at Chapel Hill.

(Dr. Janet Fischer read a prepared manuscript See Vol. 26, No. 10 - NCMJ, Oct. 1965, pp. 431.)

 $PRESIDENT\ RAIFORD$: Thank you, Dr. Fischer.

The next speaker is Dr. James F. Glenn, Professor of Urologic Surgery at Duke University Medical Center, Durham.

(Dr. Glenn's presentation will be presented to the North Carolina Medical Journal for editorial disposition.)

PRESIDENT RAIFORD: Thank you, Dr. De-Maria, Dr. Fischer and Dr. Glenn. We are very proud to have such an abundance of talent within our North Carolina professional family. I can assure you that my omission of detailed biographical data was not due to lack of appreciation, but lack of time.

The lawyers have a word for it; things speak

for themselves. I think our speakers speak for themselves.

(Recess)

PRESIDENT RAIFORD: Ladies and gentlemen, I will not reconvene the recessed session of the First General Session.

A friend and colleague of mine in the Western part of the State has been described as a man of few words who uses them frequently. Our speaker this morning can be best described as a man of many words who uses them sparingly and effectively.

I will omit any detailed biography but present to you Dr. Charles Cameron, President of Hahnemann Medical College of Philadelphia, speaking to you on Fifty Years of Cancer Control.

(Dr. Cameron's presentation will appear in the North Carolina Medical Journal.)

PRESIDENT RAIFORD: I hope you will agree with my evaluation of Dr. Cameron's knowledge and ability.

Our next speaker will be introduced by Dr. Rhodes. I will ask him to escort Dr. Adams.

DR. RHODES: Each generation produces few men who have the talent to develop and to create, and to build an empire. The late Dr. Frank Lahey was such a man, but the inexorable toll of time decrees that each of these must have a successor.

It is my proud privilege to present to this audience my friend and classmate, Dr. Herbert D. Adams of Boston, Director of Lahey Clinic, who will talk to us about "The Metastasis of the Surgeon."

(Dr. Adams read a prepared manuscript annexed hereto.)

PRESIDENT RAIFORD: Thank you, Dr. Adams. I hope you will appreciate the changes in store for the surgeon, especially those of you like me who are surgeons, and are so deeply involved in this current metastasis.

We have a few minutes before the next function, and I will declare a brief recess.

(Recess)

PRESIDENT RAIFORD: We will reconvene the morning session.

I will now recognize Dr. Philip Naumoff of Charlotte, Chairman of the Public Relations Committee.

DR. NAUMOFF: Mr. President, it is my pleasure to present to you one of the finest television stars of our time, and a man who has done more for medicine than many of us, Richard Chamberlain.

PRESIDENT RAIFORD: Ladies and gentlemen, it was my privilege last June, in San Francisco, at a meeting of the House of Delegates, to see Mr. Raymond Massey, Dr. Gillespie, presented and receive an award from the American Medical Asso-

ciation for his contributions to the art of medicine. At the same time, an award was tendered to Mr. Chamberlain, Dr. Kildare. Unfortunately, he was unable to be present, and we still remember, Mr. Chamberlain, your very generous and thoughtful telegram.

Today, we are singularly honored in North Carolina that the Medical Society of the State of North Carolina has been honored by the presence of Dr. Kildare.

Mr. Chamberlain, representing as steward of the Medical Society of the State of North Carolina, it is my great pleasure to present you with this award which reads as follows:

"To Richard Chamberlain, Dr. Kildare, for his excellent and effective portrayal of the young physician in training.

"Presented by the Medical Society of the State of North Carolina on this, the 3rd day of May, 1965."

Mr. Chamberlain, we thank you.

MR. RICHARD CHAMBERLAIN: Thank you very much, Dr. Raiford.

Ladies and gentlemen, we all work very hard out on the West Coast, Raymond Massey and I, and the producers of the show, to make it as authentic and as positive as possible within the extraordinary limitations of the medium, and it is a great compliment to us when a medical association such as yours likes the show and deems it worthy of your attention.

I am very grateful to you. We are all very grateful to you. Thank you very much.

PRESIDENT RAIFORD: I will now turn over the Chair to Dr. Poteat, First Vice President.

(Dr. Poteat assumed the Chair.)

CHAIRMAN POTEAT: Ladies and gentlemen, I have the pleasure to present Dr. Curtis Wood, the Medical Field Consultant, Human Betterment League, Ft. Washington, Pennsylvania, who will speak on "Medicine's Responsibility in the Population Explosion."

(Dr. Wood's address will be presented to the editorial board of the North Carolina Medical Journal.)

 $CHAIRMAN\ POTEAT$: Thank you very much, Dr. Wood.

Chub Seawell said that an intellectual was a man who had more education than his intelligence could tolerate.

We have had a beautiful philosophical program this morning, and in behalf of the Medical Society of the State of North Carolina, I wish to express our sincere thanks to Dr. Cameron, Dr. Adams and Dr. Wood, for being here, and also to the program committee who made it all possible.

Are there any announcements? If not, I declare this session adjourned.

(The meeting adjourned at twelve-thirty o'clock.)

SECOND GENERAL SESSION

Tuesday, May 4, 1965

The meeting convened at 9:00 a.m., Dr. Theodore S. Raiford, President of the Society, presiding.

PRESIDENT RAIFORD: I will now convene the Second General Session, and the first item on the program is a "Symposium on Shock," which will be moderated by Dr. Nathan Womack, Professor of Surgery at Chapel Hill.

I will introduce Dr. Womack first, and let him in turn introduce his panelists.

(Dr. Nathan A. Womack assumed the Chair.)

MODERATOR WOMACK: The job that I have is going to be very simple. Dr. Raiford said I have the function of introducing the speakers, and then maybe defining the issue for discussion, and then the questions.

The speakers will be Dr. Harold Green, behind me, of Bowman Gray, Dr. Lewis Rathbun to my right of Asheville, and Dr. Sabiston, on the end there, from Duke.

I will introduce Dr. Ivan Brown in a little while.

I don't believe I can let the introduction of Dr. Sabiston go by quite so briefly, since this is his first formal presentation to the North Carolina State Medical Society. Dr. Sabiston is one of us who departed for some years and came back, and we are so happy to have him; and the whole group at Chapel Hill are enthusiastic about having him so close. I don't have a better compliment that I could pay a man than to say that a Professor of Surgery at Duke is welcomed enthusiastically at Chapel Hill.

Dave, we're glad to have you with us.

Now each of the speakers will present their points of view in 15 or 20 minutes. When they are through, the subject will be placed before the floor for discussion. If you don't have anything to argue about, maybe we'll start arguing among ourselves up here.

The subject of shock is certainly one fit to argue about. It is hard to define it, which means that there will be some remarks made, I'm quite sure before we sit down, that go a little bit aside from the central theme.

I think the first good description of shock I recall is that one of the Second Book of Prognostication of Hippocrates: a sharp nose, hollow eyes, collapsed temples, ears cold, contracted, the lobes turned out, the skin about to fall, being rough, distended or parched, the color of the whole face being black, livid or lead color.

So the description of shock is very old indeed. I think this is important, because here is the recognition of a clinical state long before many of the tools that we have at the present time were available.

But we got into trouble on it. We got into

trouble primarily I think through semantics. Here is one a century ago: Shock is a manifestation of a rude unhinging of the machinery of life.

I read that and recalled a statement of Goethe's, I think something we will have to watch maybe this morning: "Just when comprehension fails, up steps a word to act as deputy."

Watch for names that we cannot define.

Some think of shock as hypotension. I notice that is the common thing around our place at any rate. If a house officer says this patient came in in shock, you're not looking for a pinched nose or livid face, or lead-colored face. You think of a person in hypotension. Hypotension is the first thing that one thinks of today in the emergency room in shock. And some shock is hypotension.

Again we find that shock is a failure of blood flow and not of blood pressure, and there have been several people who made quite an issue of that. Again, shock is not that at all, but is peripheral vascular collapse.

This was a very important concept that was put out by old Dr. George Crile, the present Dr. Crile's father, who saw shock as peripheral vascular collapse. There comes that word—acting as deputy. And yet it was an important generalization, and I think we profited by it.

Again a recent paper on shock says "a failure of peripheral perfusion." It had nothing to do with the heart; it had nothing to do with the blood pressure; it had nothing to do with the arteries or veins, but had to do with the capillaries alone and the perfusion.

Well, what is shock? And not being able to tell you. I think we might start in on the discussion.

We are fortunate to have as our first member of the panel one who is not just a physiologist, but I think anyone who had read a paper having to do with the basic mechanism of small vessel blood flow will encounter the name of Harold Green. If you look for a good review of the subject, you will find Harold Green, one in particular of the physiologic reviews a year or two back that comes to my mind.

Since the problem of shock cannot be disassociated from the flow of blood through small vessels, and since the flow of blood through small vessels cannot be disassociated from the name of Harold Green, I think your Program Committee did the only logical thing that they possibly could do, and had him start off as the first speaker.

(The papers of the three panelists will be printed as a Symposium on Shock in the North Carolina Medical Journal.)

MODERATOR WOMACK: I will ask the members of the panel to come up front and be seated, so that you can ask questions or enter into a discussion.

 $(A \ \ question \ \ session \ \ followed.)$

(Dr. Raiford resumed the Chair.)

PRESIDENT RAIFORD: Thank you, Dr. Wo-

mack, and panelists for a most illuminating and informative discussion. I think we are just as proud to have within our membership such talent as this.

I think it right and proper that we declare a two-minute stretch break, but since it is a rather close schedule, I would ask you to reassemble within a very few minutes.

(Recess)

PRESIDENT RAIFORD: I will ask Dr. Wayne Benton to assume the Chair as Vice President.)

(Dr. Benton assumed the Chair.)

DR. BENTON: Ladies and gentlemen, it is now time for the annual address of the President, Dr. T. S. Raiford. As your President, he certainly needs no introduction, and I will be damned if I'm going to give him one.

(Applause)

(President Raiford read a prepared manuscript.) (The delegates rose and applauded.)

DR. BENTON: Thank you, Mr. President. It is now my pleasure to introduce our President who will introduce our next speaker. Dr. Raiford.

(President Raiford resumed the Chair.)

PRESIDENT RAIFORD: As I mentioned earlier, one of the greatest pleasures, and one of the things I am most grateful for is the privilege of introducing our guest speaker.

To all of us, he is an articulate crusader, an advocate of free medicine and good medicine. To me he is that, but in addition a good friend.

Dr. Edward Annis needs no introduction whatsoever, and Ed, I am very happy to have this honor to welcome you with us.

(The address of Dr. Annis will be presented to the North Carolina Medical Journal for editorial disposition.)

(The delegates rose and applauded.)

PRESIDENT RAIFORD: Thank you, Dr. Annis, sincerely, for coming to North Carolina again and for bringing us a truly brilliant message.

(The meeting adjourned at twelve-fifteen o'clock.)

THIRD GENERAL SESSION

Wednesday, May 5, 1965

The meeting convened at 9:00 a.m., Dr. Lenox Baker presiding.

(A presentation entitled "Can 'Medicine' Overtake Technological Civilization" was presented by Dr. W. L. Wilson following the Annual Report to the Medical Society of the North Carolina State Board of Health at the Conjoint Session.)

(Dr. Wayne Benton assumed the Chair.)

CHAIRMAN BENTON: The Chair now recognizes Dr. Lester Crowell, who is Chairman of the Committee on Scientific Awards, who will give his report.

DR. LESTER A. CROWELL, JR.: Ladies and Gentlemen of the Society: We come to a part of

the program that it gives me a great deal of pleasure to announce the awards for the 1964 session of the State Society.

There are three of these awards which are given in recognition of excellence of presentations before the 1964 members of the Society. Only active members of the Society are eligible to receive the awards.

Would Dr. C. C. Fordham come forward?

It gives me a great deal of pleasure as Chairman of the Awards Committee, the Committee on Scientific Awards, to present to you, Dr. Christopher Columbus Fordham, III, a member of the faculty of the University of North Carolina Medical School, the Moore County Award, which is given by the Moore County Medical Society for your presentation before the Session on General Practice of Medicine during the 1964 session entitled "Problems in the Diagnosis of Renal Parenchyma Disease." Congratulations. (Applause)

Dr. Robert Stevenson Lackey. As Chairman of the Awards Committee, the Committee on Scientific Awards in the State Society, it gives me pleasure to present to you, Dr. Robert Stevenson Lackey, radiologist of the Charlotte Memorial Hospital, the Wake County or Cooper Award given by the Wake County Medical Society in honor of Dr. Cooper, for your presentation for the Section on Radiology during the 1964 session of the Society, entitled "Special Procedures in a Community Hospital." (Applause)

Dr. J. W. Eades and Dr. Hilliard Foster Seigler. This is the Gaston County Award for the best audio-visual presentation before the 1964 session of the Society. This is Dr. Joseph William Eades, who is receiving on behalf of himself and Dr. Hilliard Foster Seigler jointly the Gaston County Award. Drs. Eades and Seigler are members of the faculty of the University of North Carolina Medical School at Chapel Hill, and it gives me great pleasure to present these awards to you and to Dr. Zeigler. (Applause)

CHAIRMAN BENTON: Thank you, Dr. Crowell.

The Chair now recognizes Dr. Harry B. Underwood, who has a presentation of the AMA-ERF checks to Duke, University of North Carolina, and Bowman Gray School of Medicine.

DR. H. B. UNDERWOOD: Are the representatives, Deans or representatives of the schools, various medical schools of our State, present?

It is rather impossible to know exactly how much the doctors in North Carolina really give to medicine throughout the year. The AMA-ERF Fund is only one channel, and I am sure there are many loyal alumni of the schools who give directly to the schools rather than funneling their money through the fund.

I am sure that all of you physicians have throughout the year received much information concerning AMA-ERF. I hope it doesn't all go into File 13. But the one thing that impresses me is the fact that our schools do receive so much more than we as physicians give in this State. It is only because of the excellence of our schools that we do get this extra money coming back to the State.

It is with pleasure then, for this part of the program, that I say this. There are three definite parts of the AMA-ERF program; one is research, one is the student loan fund, and the other is to help medical schools. And as you know, if you give money to the fund, you can give it to any one of these projects.

What we are participating in at the present time is the money coming back to our medical schools. So it is with a great deal of pleasure that I present the following checks to Duke University School of Medicine \$9,206.90.

And to the University of North Carolina, \$7,-275.68.

And to Bowman Gray School of Medicine, \$5,-602.22.

If you added all this up, it comes to somewhere in the neighborhood of \$20,000; our contributions fund through AMA-ERF this past year was approximately \$10,000.

I would like to take this opportunity to encourage all of us in this present year to try to give just a little bit more; even if we each gave \$5, we would almost double what we're putting in. Thank you. (Applause)

CHAIRMAN BENTON: The Chair now recognizes Dr. Barnes Woodhall and his distinguished group of panelists.

(Dr. Woodhall assumed the Chair as Moderator.)

MODERATOR WOODALL: Ladies and gentlemen, we have our end men and center men established here. This panel opens under rather mysterious circumstances. There is no title in the program, but I am here to tell you that these people are going to speak about medical education.

If you look a little further down on your program, you will recognize the fact that there has been a striking change in medical school leadership in the State. The program states that Dean of the North Carolina School of Medicine is Isaac Taylor, and he has changed to the Bowman Gray School.

I have been in North Carolina since 1937, and I have seen some rather remarkable schools, but I simply don't believe this.

The issue, of course, is a burning one in the State for many reasons. As you know, the State Legislature is interested in new medical school projects. There is an impending report called the Trudell Report. We all recognize the need for physicians in the future, and it is important for countless other reasons.

The three new Deans will speak shortly; but for the benefit of any strangers in the audience — and I know there are none, but having been a dean myself, and having been brought up by some of these people here, I do want to ask you to acclaim three great pioneers in medical education, and I should like to present them if they will stand: Coy Carpenter, Reece Berryhill, and Dave Davison. (Applause)

Ladies and gentlemen, this concludes any formal part of this program. I have not asked the former deans to make a prepared statement. However, I have reserved this time for those of this group who wish to walk down the long hill that Dr.

Anlyan described.

DR. WILBURT C. DAVISON: I was very much abused about that report of medical schools—by the report of the Legislative Commission in the papers this morning that two-year schools were a passing fad, forgetting entirely that Harvard has been a two-year school right from the beginning. They have the first two years out on Longwood Avenue, and the next two on Masachusetts Avenue, and so on.

At Oxford and Cambridge, you have your premed work there, and then you go to St. Bartholomew's, and so on.

We at Duke tried to run a two-year school for the last two years, but it so offended the Rockefeller Foundation, they gave me \$300,000 not to do it, and I always felt I sold my birthright for a mess of porridge.

The thing I wanted to mention is the fight about the two-year school which they said was a passing fad — in 1935. Bill Cudder was a secretary of a committee in the AMA and got the idea that two-year schools weren't as good as four-year schools. So he got the AMA to approve his recommendation that they be abolished by 1939, but it had to be approved by the Association of American Medical Colleges.

Well, I knew I would be crucified in North Carolina if that thing went through, because with an excellent two-year school at Chapel Hill, and an excellent two-year school at Wake Forest, they certainly would blame it on me.

At a subsequent meeting it was moved that Bill Cudder's motion be tabled, which would kill it, and Chesney from Hopkins seconded, and I seconded it, and there has been no peep about two years since. Whether it's a passing fad or not, I don't know. It's in that report.

DR. W. REECE BERRYHILL: I had not intended to speak on the subject, and perhaps I shouldn't, since I happen to have been a member of the Governor's Commission. At the same time, I am emboldened to do so because there is no place in North Carolina that I feel more at home than I do here on my native soil, and I think I would not be true to my ancestors who signed a very important document 170 years ago if I didn't speak my conviction.

Dr. Davison and I have carried on a friendly

feud for 30 years. It really stems from the Johns Hopkins alumnus versus the Harvard Medical School alumnus, among other things. But I should like to speak for a few minutes both philosophically and scientifically about the place of the two-year medical school in medical education.

Whether you know it or not, there are two people on this rostrum who have had the most unique experience, and I think the most intimate knowledge with respect to two-year medical schools than any two people still active in medical education. They happen to be Dr. Coy Carpenter and myself.

Our experiences began 40-odd years ago as students in the two-year schools of our respective alma maters. Years later, we each came back as a member of the faculty of those two schools, with one objective in mind, and one only: to help in so far as we could to strengthen the teaching, the faculty of those two schools, of each school, with the hope — although it was forlorn at that time — that those two schools would be expanding.

We, under pressure, accepted the deanship of the two-year school, at each of our alma maters, and as conditions changed, became deans of those expanded schools.

I would submit therefore, ladies and gentlemen, that from the standpoint of the student who went to a two-year school, from the standpoint of a faculty member and an administrative officer, we probably are more intimately knowledgeable of all the problems than anybody else.

Philosophically, in the 1960's, I think a two-year medical school is an anachronism in medical education. Since 1913, medical schools all over the world have been trying to bridge the gap and eliminate the dichotomy between basic science education, or the education in basic sciences, and in the clinical field. We hoped we had gotten to the point where everyone accepts the fact that to be a competent physician today, with the rapid changes in medical knowledge and the advances, that our able younger predecessors have pointed out, that the physician of tomorrow has got to be a practicing chemist-physiologist-pathologist, etc.; otherwise, he isn't bringing the best medical care to his patients.

It is almost impossible to do this in a two-year school unless from the very beginning one starts clinical departments. And it just seems to me it is unsound to believe that one can, in this era, advocate two-year schools anywhere.

Now I realize that in speaking as I am, I am subject, as I have been for a long time, to being a prejudiced narrator, but I should like to quote my favorite political hero, the late Alfred E. Smith, and say "Look at the record," because the one condition which I laid down when the university asked me to come back there in 1932-33, was that it adopt the policy, no matter how long it took, of expanding the university medical school.

In 1941, when I was asked to become dean of the school, that again was the only condition which I laid down, and to which the university committed itself.

For the last three years, or rather another record — I happen to have been the Executive Council member of the Association of American Medical Colleges when the crash program of advocating the reinstitution of two-year medical schools was proposed. I don't think it was as crash as the crashest of all the crash programs in the Great Society which has been proposed today, the heart, cancer and stroke institutes; but still it was a crash program. And I was the lone dissenting voice raised against this, on the basis of my firm conviction and on the basis of experience.

I am somewhat reassured in 1965 that some six or eight years later, many of the members of that Council who voted to advocate this had now changed their minds.

In the last few years, because of my experience with two-year medical schools, I have been asked to serve as a consultant to several institutions which were considering this. I made the same plea to the President of the Board of Trustees, and I am happy to say that at least one of those, Brown University, is now making definite plans to proceed with the expansion of their initial efforts in medical education and have appointed a full-time Professor of Medicine and a full-time Professor of Surgery, although they have not yet accepted into what we would call the anatomy and physiology and whatnot of basic science their first students. And the same is taking place in a general way in Arizona.

So, Dr. Davison, in some respects I am sorry to disagree with you, but those are the facts of the matter, and I think that the commission, irrespective of any proposal, was wise in saying that in this era, two-year medical schools are not what they need.

MODERATOR WOODHALL: I simply want to say from my former experiences as a dean, I was fairly confident that if I could get these former deans to talk — you may have one word.

DR. DAVISON: I went to a two-year school. I took my preclinical work at Oxford, and my clinical work at Hopkins, and I must say that Coy Carpenter, Reece Berryhill and I have survived.

MODERATOR WOODHALL: Coy, your name has been mentioned. Would you speak?

DR. COY C. CARPENTER: I guess I could almost say the same thing that Reece has said about my disagreement the last several years with my good friend Wilburt Davison, I hope without being disagreeable.

As a matter of fact, I have always said that our success in transforming a two-year medical school to a four-year medical school was largely through the support nationally and in other areas, that Wilburt Davison gave Wake Forest. We will always be grateful to him.

I don't believe that that particularly proves a

point. A lot of things are surviving in spite of their environment, not because of it. It may be that we are surviving having been students in two-year medical schools in spite of the system and not because of it.

As a matter of fact, I would say that some of the finest alumni we have by far in this State graduated the old Wake Forest two-year school.

But as Reece has said, we came into existence largely in the 1930's as a four-year school because it had been determined by a careful study that two-year medical schools were obsolete, and certainly Reece is right, and I have said this to my good friends in the State who were talking about establishing a two-year medical school — I said "Fine, call it a two-year medical school, but in fact you've got to build for a four-year medical school."

I know in a majority of institutions we bring clinical medicine in the first two years and basic sciences in the last two years to such an extent nowadays that they cannot be separated.

I really think, Dave, what you're talking about when you say or use these illustrations of the two-year schools, you're really talking about divided schools. You might call Emory University a two-year medical school. I dare you do that — in Georgia. But they have the first two years out on the campus and the last two years at Grady Hospital downtown. They are still one faculty. And there are a good many schools that have the basic sciences one place and the last two years another.

But certainly in the present day knowledge of medicine, medical education, there is no institution that will continue to operate for long a two-year medical school; and if I know this State, it will be a four-year school before you can say "scat."

I would support the idea, if they're going to build a school at all anywhere, that you build and call it a two-year school if you want to, but you certainly cannot operate a school without a teaching hospital, and professors of medicine, etc., who are at the elbow of the basic science people in the first two years. Thank you.

MODERATOR WOODHALL: A moderator, of course, is an innocent bystander, but does have the privilege of making his own rules, and I will now accept questions from the floor, and I shall also give this privilege to the microphone for anyone who wishes to speak further.

All doctors should be critics of medical education, using the word in a constructive way. What critics do I see here?

QUESTION: I would like to direct this question to all three deans, and probably Dr. Anylan might be able to start off.

Granted that the medical school curriculum has to be changed today, and that the undifferentiated doctor can no longer be graduated; the so-called blast graduate is no longer feasible. What plans are being made in the curriculum to graduate erythrocite doctors who will become red cell graduates, or physicians that will provide essential family medical care?

DR. ANLYAN: In our new curriculum, we have made provisions for the potential family practitioner and general practitioner. Essentially, he, too, would not graduate as an undifferentiated blast form, but would graduate with experience that would benefit him and prepare him for either a mixed internship, a rotating internship, or the medical internship plus a mixed internship.

So that for instance, in our new curriculum, the second and third years are reversed. The third year is a basic science year, and the fourth year is the last clinical year. In his third year, the potential general practitioner would take one of the three courses. This is selected from our catalogue: the more general courses in microbiology; there will be a course offering in the third year bacteriology and immunology. In pathology — the general course — pathologic basis for clinical medicine, and in pharmacology, a clinical pharmacology course.

In his fourth year, he would take a course offering in psychiatry, in clinical psychiatry, and in radiology; he might take the offering in x-ray diagnosis. In surgery, he might be assigned to the emergency room for the surgery of trauma course, or to orthopedics. And he would get pediatrics or medicine, depending on what type of internship he would go into.

So that we would essentially avoid what I said earlier, reduplication of experience that he will get in the post-doctoral phase.

In the summer we hope he would accept Dr. Davison's preceptorships, either working with family physicians or working in community hospitals between his second and third year, and his third and fourth year.

I hope, Phil, that that may answer your question partially.

MODERATOR WOODHALL: Would you care to ask something further?

QUESTION: I would like to hear from both Wake Forest and the University of North Carolina what their plans are in this respect.

MODERATOR WOODHALL: I will ask Ike Taylor to speak first then.

DR. TAYLOR: We have two parts to my statement on this. In the first place, we are undertaking in our school an extensive curriculum study and review. Dr. David Hawkins, Professor of Psychiatry in the school, is going to be the director of that study, and so for the long haul, I cannot be very specific about this. It obviously is a question of great importance that we consider our curriculum.

More immediately, we are making real progress in expanding the experience of our students in the community hospital setting. For several years at Chapel Hill, our students got almost all of their formal clerkship in the North Carolina Memorial Hospital. There are many reasons for this. But now we are in a position where we can begin to provide for our students experience in selected community hospitals, and we are under way in working on that.

We also have in the North Carolina Memorial Hospital, and directed at the local community there, a section under Dr. Robert Huntley on family care. And this is still in an embryonic stage, but Dr. Huntley's clinic is providing comprehensive and continuing family care for a group of now, I think, 50 families in Orange County. And this will be developed to the point where our medical students will participate in this program.

DR. MEADS: We are still studying Dr. Anlyan's statement that we do not produce megaloblasts at the end of four years. Our faculty still believes that this is still the purpose, a megaloblast who is capable of going into any one of several specialties, including the specialty of family practice, which I believe is a specialty and must become a stronger specialty. There is no question of the need.

I would say that we have heard that in rotating through the various clinical disciplines, a student is exposed primarily to specialists. Therefore, he is not in fact a true megaloblast, undifferentiated. I would certainly tend to agree with his statement, and our plans are to expose the student to the basic core of family practice, which I believe is continuing comprehensive care. This is by definition of the Academy of General Practice the basic core of family practice. And we will be establishing in our expanded facilities a special teaching clinic, which will be a comprehensive care clinic similar perhaps to the format at Chapel Hill, but I think perhaps a little different, in which we hope the student will be a family physician in a sense, have a series of selected patients, probably representing a number of chronic diseases, which he can follow over a period of a minimum of three months.

At that time, there will be many conferences in which the principles of continuing comprehensive care will be given to the student. This is a mandatory rotation. I think this is about all the medical school can do in its four years, with one exception, and that is to allow the student to take what I think is a very fine opporunity to paricipate in the North Carolina Academy of General Practice Program, the two-week preceptorship, and have an opportunity. Our students who have taken this have been greatly impressed, have thought it was a very important experience to get into the field and see what family practice is like.

So those two things are in our plans to try to increase participation of our students in the elected two-week program of family practice offered by the Academy in developing a core experience in the continuance of family care.

DR. ANLYAN: Dr. Woodhall regretted that he has to catch a plane and asked if I could substitute for him for the last few minutes.

Dr. Rankin, are there any comments that you would like to add to this discussion?

DR. CARPENTER: I would like to have a word here first. I want to say that the old saying that an institution has a lengthening shade of a great individual is true. I like to think of Wake Forest University and Medical School in its entirety, almost, as a lengthening shadow of Dr. Rankin.

He served as dean there and left in 1909. I came there as a Professor of Pathology in 1926, and my microtome had on it the sign "Dr. W. S. Rankin." I had the same equipment. And also I wanted you to know he was a good doctor. Here is one of his babies back there; the President of this Society, Dr. George Paschal, was delivered by Dr. Watson S. Rankin.

DR. W. S. RANKIN: I want to say to you that I appreciate the very cordial reception that you have given me, far beyond any merits that I may have had in my profession in either hospital work or my first task at Wake Forest College in Medical School.

This discussion has been very interesting to me although it is rather foreign from my recent experiences, and I am not going to get involved too much in the merits or demerits of the medical schools that have been very ably presented by both sides here this morning.

The main thing I wanted to do is express my appreciation particularly to Coy Carpenter who succeeded me. We got started there at Wake Forest, and I came here especially to hear one of my first babies preside as President of the North Carolina Medical Society. His father was one of my close personal friends, and I feel very close to George Paschal, both going back a generation, and I have taken a lot of pride in the way that he has grown in the Society's affairs and influence.

Thank you very much.

So far as the medical schools are concerned, the two-year medical schools, I think that's a matter that will have to be left to the American — Association of American Medical Colleges and the AMA. You've got to have your national standards, and you've got to have your national leadership, and you've got to line up behind them.

The great trouble with our profession is that we're all leaders without followers. That's emphasized at the time a person gets into a medical school

One of the major points made in the study on the basis of civilization, you've got to have leadership, but you have also got to have followship, or you can't have any kind of united efforts, and medicine has always produced an excess of leadership and a minimum of followship.

(Applause)

DR. ANYLAN: Thank you, Dr. Rankin.

I think our time is up. We would like to thank the Medical Society for having us on this program. I would like to thank Dr. Rankin, Dr. Carpenter, Dr. Berryhill, and Dr. Davison, for joining with Dr. Taylor and Dr. Meads and myself. Thank you very much.

(Recess)

DR. WAYNE BENTON: Ladies and gentlemen, it is now your pleasure to hear an address by our new President, Dr. George Paschal.

PRESIDENT GEORGE PASCHAL: Vice President Benton, Ladies and Gentlemen: I would like to take this opportunity to pay a personal tribute to the dean of deans in North Carolina, and in fact in the United States, Dr. Watson Rankin.

(Applause)

I would also like to pay a tribute, not much less, to the acting deans of our schools that are here today.

I have chosen as my topic today "1965: The Role and Responsibility of the Physician."

(President Paschal read a prepared manuscript. See pp. 229, June 1965, NCMJ.)

(The audience rose and applauded.)

DR. BENTON: A most inspiring talk. It is very obvious that George has got a lot of work cut out for us in the future, in the next year.

The next item on the program is the election of officers, which has already been done.

The next item is the presentation of the prizes. (Awarding of prizes.)

(The meeting adjourned at 11:45 a.m.)

PRESIDENT'S DINNER

Tuesday, May 4, 1965

The Banquet held at Park Center Auditorium, Charlotte, North Carolina, commenced at 7:30 p.m., Dr. David G. Welton, Toastmaster.

DR. DAVID G. WELTON: My name is Dave Welton and I want to give you a very big and hearty welcome to the Annual President's Ball and Banquet. This is the first time in 23 years that this function has been held in the Queen City, and we are delighted to have each and every one of you here.

(Introduction of those seated on the dais.)

It is said that men become great for three reasons: first, by native endowment, second, because of great opportunity; and third, because of great will to serve. Ted Raiford, we salute you as a great man, and I call now upon Amos Johnson for a special presentation.

DR. AMOS JOHNSON: Ted, a number of years ago, a really great North Carolinian who was President of our State Medical Society said that to be selected and elected from among those who know you best to be the leader, to be the President of the association of North Carolina doctors, is the greatest honor that can come to anyone.

A few years after that, we had a president whom I seem to remember took a special interest in me and also in you, and were he privileged to be here tonight, he would be the person who would be presenting you with this medal which I will present to you within a few minutes. That's Westbrook Murphy. The other one is Paul McCain, who is one of our great presidents of the Medical Society of North Carolina.

Ted, those of us who have known you over the years have known the work you have done, have known the obstacles that you have had. Those of us who know you so well and love you so well think that you are one of the greatest presidents that we have ever had, and it is a distinct honor for me, on behalf of all of the members of the Medical Society of the State of North Carolina, on behalf of all of those who are here tonight, to present to you this medal which is to be worn by you with honor from here on, which is to show to all people that you have been the leader of medicine in the State of North Carolina for your year as its President.

I congratulate you, and we are grateful to you for what you have done, Ted. It's a real pleasure and an honor for me to have this opportunity to do this. (Applause)

DR. THEODORE RAIFORD: You can see why my job has been easier, with friends and moral support like that of Amos.

To all of you I say thank you for your support, and God bless you.

DR. WELTON: The next event, one of great official importance, is the swearing in of our President-elect as our next President, George Paschal. It will be Ted Raiford's pleasant duty to perform this ceremony.

DR. RAIFORD: This is always a pleasure, especially when I present to you such a capable man as my successor, George Paschal.

(Swearing-in ceremony.)

(President George Paschal made an address which will be printed in the North Carolina Medical Journal.)

(Applause)

DR. WELTON: Thank you so much, George.

It is a new feature of this program, and our pleasure and honor, to recognize the new members of the Fifty Year Club, and I shall call upon Hubert Poteat to do so.

DR. HUBERT POTEAT: Mr. Toastmaster, Mr. President, as Vice President of the Medical Society of the State of North Carolina, and by authority of the Executive Council action which has been adopted by the House of Delegates of the Medical Society of the State of North Carolina, I hereby recognize the Fifty Year Club of the Medical Society of the State of North Carolina, composed of the members of this Society who have gained that distinction by a fifty year period of active practice and medical service within their lifetime.

It will be the purpose of this State Society to so recognize those on the occasion of each annual meeting, which will give due recognition to the continued surviving members of this club. I wish on this occasion to extend to this group, whose names I will call, the felicitations, congratulations, and admiration of the Medical Society and all the members, as well as your many friends, for the wonderful attainment represented by each of you and by you as a group collectively.

It gives me a great deal of pleasure to present for the Medical Society of the State of North Carolina, this Fifty Year Club, and to grant to each of the new members a scroll which may serve through posterity to indicate your achievements and distinction in this connection. I am also happy to present to you a token which you may possess and cherish and wear to indicate to your fellow physicians and to your friends and acquaintances in general the distinction which has been extended to you by reason of this action today.

Alexander Chester Bulla, a native of Randolph County, his dream and ambition as a young man was to become a general practitioner in a small community.

A third generation representative of a family that produced seven physicians, graduate of the North Carolina Medical College, he came under the influence of the late Dr. George M. Cooper, who diverted him into public effort. He became, after his graduation in 1915, school inspector for the State Board of Health, Director of the Public Health of Forsyth County, and for 37 years Health Director for Wake County, where he was honored in 1960 by the dedication of the A. C. Bulla Health Center.

A devoted public servant, esteemed friend of his colleagues, and since his retirement in 1958 intrepid world traveler, Dr. Bulla has maintained a record of perfect attendance at the annual session of this Society for 49 years.

The Medical Society of the State of North Carolina, in recognition of his significant contribution to public health and marking 49 years of perfect attendance at its annual sessions, confers upon Alexander Chester Bulla this Award of Merit, May 4, 1965, at Charlotte, North Carolina.

Signed, Theodore S. Raiford, President; Charles W. Styron, Secretary.

Dr. Bulla, in my own behalf, I extend my very sincere congratulations, and on behalf of the members of this Society, may God bless you sir. (Applause)

(The list of Fifty Year Club members was called.) (See pp. 78, Supplement to NCMJ.)

(Applause)

DR. WELTON: It is now my pleasure to introduce to you the speaker of the evening, Mr. Tom Anderson, a native of Tennessee now living in Nashville, a graduate of Vanderbilt University. Mr. Anderson is President of Farm & Ranch Publications, the largest group of state farm magazines in the world, a total of 10 or more publications devoted to agriculture and dairying in the South.

I found out a secret about him too a little while ago. He never was a farmer. He and I have several things in common. Neither one of us has ever been a farmer; he never took a course in journalism, and neither did I; but you don't see where it got him to be a high school dropout.

He has a very famous editorial called "Straight Talk," and this is syndicated throughout much of the country, and is the most quoted and most reprinted in the farm field.

Mr. Anderson has twice received the Liberty Award of the Congress of Freedom, and the Freedom Award for outstanding achievement in bringing about a better understanding of the American way of life.

After making several inquiries, I discovered that everybody who heard him speak in Asheville several years ago is back here to hear him tonight. No greater compliment could be paid to any speaker.

Welcome, Mr. Anderson. (Applause)

(Mr. Thomas Anderson presented an address which will appear in the North Carolina Medical Journal.)

(The formal meeting adjourned at ten-fifteen o'clock.)



EARLY HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM ORGANIZATION TO 1804

Date	Place	President	Vice Presidents	Corresponding Secretary	Secretary	Recording Secretary	Treasurer	Censors
17, 1799 April 16, 1800	Raleigh	Richard Fenner	Nathaniel Loomis John Claiborne	Calvin Jones		Wm. B. Hill	Cargill Massenburg	Sterling Wheaton James Webb Jas. John Pasteur Jason Hand
1, 1800	Raleigh	Richard Fenner			Sterling Wheaton			
1, 1801	Raleigh	John C. Osborne	Thomas Mitchell Richard Fenner	Calvin Jones	Sterling Wheaton		Cargill Massenburg	James Webb John Sibley
	Raleigh	John C Osborne		Calvin Jones				
	Raleigh	John C. Osborne		Calvin Jones				
	Raleigh	John C. Oshorne		Calvin Jones				

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1965 *Missing Data Not to be Found in Record

Oate	Place of Meeting	Number in Attendance	President	Vice Presidents*	Secretary	Treasurer•	Members on Roll*	Honorary Members	Honorary Fellows*
1849	Raleigh	25	F. J. Hill		W. H. McKee		25		
1850	Raleigh	21	E. Strudwick	F J Haywood, C. E. Johnson J E.	W H McKee	W. C. Will			
1851	Raleigh	23	E Strudwick	Williamsor, W. G. Thomas C. E. Johnson	W H. McKee	W. G. Hill	38 46	9	
1852	Wilmington	38	J. E. Williamson	Thomas N. Cameron, William G. Hill, Johnston B. Jones, N. J. Pittman	E. B. Haywood	J. J. W. Tucker			
1853	Fayetteville	24	J. E. Williamson	William G. Hill, Johnston B. Jones, J. B. G. Myers, N. J. Pittman	W. W. Harris		72	12	
1854	Raleigh	37	J. H. Dickson	N. J. Pittman, J. B. G. Myers, J. Graham	S. S. Satchwell	Daniel Dupree	80	14	
1855	Salisbury	23	I. H. Dickson	J. Graham Tull. Owen Hadley, A. D. Mc-		Daniel Dupree	84	17	
1856	Raleigh	35	C. E. Johnson	Lean, Hugh Kelly Marcellus Whitehead, F. R. Go'son, John-	S. S. Satchwell	J. B. Dunn	96	18	
1857	Edenton	25	C. E. Johnson	ston B. Jones, O. F. Mauson. Marcellus Whitehead O. F. Manson, H. W.	S. S. Satchweil	J. B. Dunn	101	22	
1858	New Bern	69	W. H McKee	Faison E. T. Gibson Edward Warren, C. W. Graham, Caleb	W G. Thomas	J. B. Dunn	113	16	
1859	Statesville	81	W. H. McEcc	Winslow A B Pierce James G. Ramsey, P. F. Hines, J. R	W. G. Thomas	J. B. Dunn	172	18	
1860	Washington	64	N.J. Pittman	Mercer, W. T. Howard. P. T. Henry, R. H. Winborne, M. White- bead, T. S. Leach	W. G. Thomas	C W. Graham			
1861	Morganton	23	N. J. Pittman	J. S. Leach J. J. Summerell C. T. Murphy, G. W. Hodges, W. A. B. Norcom E. Burke Haywood, R. H. Winborne, W. L. Barrow, J. W. Jones	W. G. Thomas	C. W. Graham	233	18	
1866	Raleigh	20	J J Summerell	E. Burke Haywood, R. H. Winborne,	W. G Thomas	C. W. Graham	244	18	
1867	Tarboro	41	W.G Thomas	W. L. Darrow, J. W Jones	W. G. Thomas. S. S. Satchwell.	C. W. Graham C. W. Graham	288	ii	
1868	Warrenton	27	S. S. Satchwell	Hugh Kelly, George A. Foote, Charles J. O'Hagar, J. H. Baker Thomas E. Wilson, A. B. Pierce, C. T.	Thomas F. Wood	7 77 7			
1969	Salisbury	36	F. B. Haywood	Thomas E. Wilson, A. B. Pierce, C. T.	Thomas F. Wood	J W. Jones	- 1	- 1	
1870	Wilmington	38	C. J. O'Hagan	Mari by, M. A. Locke. E. A. Anderson, F. N. Luckey, W. R.	Thomas F. Wood	J W. Jones	- 1		
1871	Raleigh	35	Hugh Kellev	Sharpe, R. I. Payne D. N. Patterson, R. C. Pearson, J. B. Seavy, G. L. Kirby		J. W. Jones	- 1		
1872	New Bern	34	W. G. Hill	H W Faison, R. I. Hicks G H Macon,	Thomas F. Wood	J. W Jones	- 1	- 1	
1873	Statesville	43	M. Whitehead	W. T. Engett William Little Charles		J. W. Jones	- 1	- 1	
1874	Charlotte	56	W. A. B. Norcom .	Duffy, P. T. Jerman J. B. Jones, R. F. Lewis, C. G. Cox. J. L.	James McKee.	H. T. Bahnson	- 1	- 1	
1875	Wilson	60	J. W. Janes	Walker Debnam, J. A. Gibson, William Little, D. N. Patterson	James McKee	H. T. Bahnson			
1876	Fayetteville	33	Peter E. Hines	J. H. Baker, G. G. Smith, T. D. Haigh	James McKee	H. T. Bahnson	148	- 1	
1877	Salem	42	George A. Foote	J. K. Hall, B. W. Robinson, A. Holmes,	James McKee	H. T. Bahnson	157		
1878	Goldsboro	79	R. L. Payne	A. A. Hill E. M. Rountree, Richard Anderson, S. B.	James McKee	A. G. Carr	177		
1879	Greensboro	100	Chas Duffy, Jr	Flowers L. A. Stith J. A. Gibson, Willis Alston, James McKee,	I. J. Picot	A. G. Carr	194	- 1	
1880	Wilmington	105	J. F. Shaffner	A. A. Hill. J. K. Hall, W. C. McDuffie, W. R. Wilson,	i	A. G. Carr	198	- 1	
1881	Asheville	92	R B Havword	R. F. Lewis J. E. McRee, W. H. Lilly, R. H. Speight,		A. G. Carr	225	- 1	
1882	Concord	65	Thos. F. Wood	W. I. H. Bellamy. T. J. Moore, D. J. Cain, S. E. Evans, John		A. G. Carr	254		
1883	Tarboro	112	J. K. Hall	McDonald A. W. Knox, J. M. Hadley, E. S. Foster,		A. G. Carr	297	- 1	
1884	Raleigh	112	A. B. Pierce	John Whitehead F. W. Potter, G. W. Grabam, R. Dillard,	L. J. Picot		310	1	
1885	Durham	173	W. C. McDuffie	G. W. Long James McKee, T. E. Anderson, W. H.	L. J. Picot!	A. G. Carr	348	7	

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1965—Continued *Missing Data Not to be Found in Record

_	Missing Data 1400 to be Found in Record										
1	Date	Place of Meeting	Number in Attendance	President	Vice Presidents	Secretary	Treasurer	Members on Roll July 15	Honorary		
33	1886	New Bern	113	Joseph Graham	H. T. Bahnson, L. J. Picot, J. L. McMillan, W. W. Falson	J. M. Baker	R. L. Payne, Jr	438	7		
34	1887	Charlotte	112	H T. Bahason	G. G. Smith, J. L. Nicholson, C. M. Van Poule, H. B. Ferguson.	J. M. Baker	R. L. Payne, Jr.	452	7		
35	1888	Fayetteville	133	T. D. Haigh	W. T Ennett, J. A. Dunn T E. Anderson	J. M. Baker	C. M. Van Poole	306	6		
36	1889	Elizabeth City	50	W. T. Ennett	W. J Jones, S. W Stevenson G W Long	J. M. Baker	C. M. Van Poole.	410	6		
37	1890	Oxford	160	G. G. Thomas	R. L. Payne, Jr., Richard Dillard, S. D. Booth	J. M. Hays	C.M. V D. L.	414	6		
38	1891	Asheville	135	R. H. Lewis	S. W. Battle, J. L. Nicholson, W. H. Lilly	J. M. Hays	C. M. Van Poole C. M. Van Poole	414 422	6		
39	1892	Wilmington	162	W. T. Cheatham	T. S. Burbank, J. W. Long, W. H. H. Cobb, W. D. Hilliard	I M II	O.M. P. D. I	421	В		
40	1893	Raleigh	221	J. W. McNeill	W. C. Gallowny, H. H. Harris, J. M. Had-	J. M. Hays	C M Van Poule	431	5		
41	1894	Greensboro	166	W H H Cobb	J. A. Holges R. W. Tate, Whas A'sten	R. D Jewett	M P Perry	447			
42	1895	Goldsboro		J H Tucker	J Howell Way W H Harrell O M Mul-	R. D lewett	M. P. Perry	454	5		
43	1896	Winston-Salem	158	R L Payne	S D Buett J P Mento ! A Bur-	R D. Jewett	M P Perry	436	7		
44	1897	Morehead City .	103	P L Murphy	roughs, J. E. Gransley, J. C. Walton, A. A. Koret, M. R. Adams,	R D Jewett	M. P. Perry	452	7		
45	1898	Charlotte	*	rancis Duffy	B. L. Long E. C. Register, A. R. Cotton, J. H. B.	R D Jewett	M P Perry	406	6		
46	1899	Asheville	152	L J Prot	Knight, F. H. Ressell I. W. Faison, J. W. White, H. H. Ledson,	R D leaett	M P Perry	437	6		
47	1900	Tarboro	115	Grorge W. Long	C. M. Van Poore, James M. Parrott!	Gen W Prisity	G T Sikes	480	6		
48	1901	Durham	186	Julian M. Baker	P. B. Williams, W. D. Hilliard, M. H. Fletcher, C. A. Julian, D. A. Stan-	Geo W Presley	G. T. Sikes	482	6		
49	1902	Wilmington	147	Robert S. Young	ton, E. M. Summerell A. G. Carr, F. D. Dixon-Carroll, I. M. Tay-	Gro W Prestry	G. T. Sikes	515	5		
50	1903	Hot Springs	155	A W. Knox	lor, J. M. Parrott E. G. Moore C. A. Julian, W. W. Me-	Geo. W. Presley.	G T Sikes,	546	5		
51	1904	Raleigh	326	H B Weaver	Kerzie J. L. Nicholson John Hey Williams John C. Rodman, S. F.	J. Howell Way	G T. Sikes	530	6		
52	1905	Greensboro	361	David T Tayloe	Pfohl. C A Julian John T Burrus I W Faison	J. Howell Way	G. T. Sikes	1,033 1,175	8 8		
53	1906	Charlotte	406	E. C. Register	L B M Brayer W H Cobb, Jr., W. O						
54	1907	Morehead City	217	Samuel D. Booth	Spencer C. M. Strong, J. L. McLaughlin, W. F.	J Howell Way	G. T. Sikes	1,234	8		
55	1908	Winston-Salem	372	J Howell Way	Hargrove I E Stokes I A Turper W H Dixon .	David A. Stanton . David A. Stanton .	H McK Tucker . H McK Tucker .	588 998	7 7		
56	1909	Asheville	337	J. F Highsneth	C. M. Van Poole, D. A. Garrison, D. O.						
57	1910	Wrightsville Beach.	276	J A Burroughst	Dees E I Wood Jola Q Myers L D Wharton	David A Stanton David A Stanton	H McK Tucker H D Walker	1 067 1 080	7 8		
58	1911	Charlotte	412	E. J. Wood C. M. Van Poule	J V McGougan, W E Warren L. N						
59	1912	Hendersonville	296	A A Kent	J.P. Monroe, W.P. Horton, J.G. Murphy	David A Stanton Pavid A Stanton	H. D. Walker H. D. Walker	880 950	8		
60	1913	Morehead City	232	J. P. Munroe	F R Harris E S Bullock, L B Morse	John A. Ferrell	H D Walker	1,133	8		
61	1914	Raleigh	431	J. M. Parrott	E T Dickinson, J T J Battle, D. E.						
62	1915	Greensboro	443	L B McBrayer	J. J. Phillips, C. W. Moseley, S. M. Crow-	John A. Ferrell	H. D. Walker	1,228	8		
63	1916	Durham	406	M H Fletcher	J L Nicholson L N Genn W. H Hardi-	John A. Ferrell	H. D. Walker	1,221	9		
64	1917	Asheville	280	Charles O'H	son	Benj K. Hays		1,228	10		
65	1918	Pinehurst.	291	Laughinghouse I. W. Faison	D J Hill J I Spruil J H Stuford Wm. deB MacNider Jos B Greene Ben	Benj. K Hays			11		
					F. Royal	Benj. K. Hays	W. M. Jones.	1,087	11		
86	1919	Pineburst	335	Cyrus Thompson.	J. W. Halford, T. W. Davis, A. McN.	SecTreas. Benj. K. Hays	Acting SecTreas L B McBrayer	1,306	11		
67	1920	Charlotte	479	C V Reynolds	H D Walker F Stanley Whitaker Thos	Benj K Hays	L B McBrayer	1,497	12		
68	1921	Pinehurst	404	T E. Anderson	C. S. Lawrence, W. H. Ward, J. M. Man- ning.	Benj. K Hays	L. B McBrayer	1,491	12		
							SecTreas.				
69	1922	Winston-Salem	507	H. A. Royster	W. T Parrott, B C. Nalle, J R Mc- Cracken		L. B. McBrayer	1,571	12		
70	1923	Asheville	356	J. W Long	F. M. Hanes, T. C. Johnson, B. L. Long			1,592	9		
71	1924	Raleigh	525	J. V. McGougan	I L. Spruill, Eugene B Glenn, D. A. Garrison		L. B McBrayer	1,604	9		
72	1925	Pinehurst	550	Albert Anderson	W. L. Dunn, A E. Bell, K. G Averitt			1,657	10		
73	1926	Wrightsville Beach.	445	Wm. deB. MacNider.	J. P. Matheson, W. W. Dawson, H. H. Bass.		L. B. McBrayer	1,663	10		
74	1927	Durham	653	John Q. Myers	J. W. Carroll, A. Y. Linville, C. H. Cocke		L. B. McBrayer	1.691	10		
75	1928	Pinehurst	611	John T. Burrus	G. H. Macon, R. F. Leinbach, W. R. Griffin		L. B McBrayer	1,738	11		
76	1929	Greensboro	671	Thurman D. Kitchin	W. L. Dunn, t Asheville, D. T. Tayloe, Jr., Washington, W. D. James, Hamlet		L. B. McBrayer	1,666	11		
77	1930	Pinenurst	701	L. A. Crowell	W. B. Murphy, Wm. E. Warren, N. B.			1,711	11		
					Adams	'	i., D. McDrayer	1,711	11 7		

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1965—Continued

te	Place of Meeting	Number in Attendance	President	President-Elect	Vice Presidents	SecTreas.	Members on Roll July 15	Honorary Members	Life Members
1931	Durham	714	J. G Murphy	M. L. Stevens	C. A. Julian	L. B. McBrayer	1,690	10	164
1932	Winston-Salem	740	M. L. Stevens	Jno. B. Wright	J. W. Davis C. W. Banner	L. B. McBrayer	1,559	10	166
1933	Raleigh	714	Jno. B. Wright .	I. H. Mannings	J. R. McCracken	L. B. McBrayer	1,363	10	181
1934	Pinehurst	728	I. H. Manning	P. P. McCain	W. G. Suiter	L B. McBrayer	1,563	10	210
1935	Pinehurst	706	P. P. McCain	Paul H. Ringer	R. L. Felts H. D. Walker J. F. McKay	L B. McBlayel	1,003	10	210
1936	Asheville	583	Paul H. Ringer	C. F. Strosnider	William Allan . J. K. Pepper	L. B. McBrayer	1,619	10	215
1937	Asheville	767	C. F. Strosnider	Wingate M. Johnson	E. S. Bullock C. A. Woodard	L. B. McBrayer	1,462	10	235
1938	Pinehurst	802	Wingate M. Johnson	J. Buren Sidbury	Jno. F. Brownsberger R. B McKnight	L. B. McBrayer	1,503	7	253
1939	Cruise to Bermuda	319	J. Buren Sidbury	William Allan	J. F. Abel C. B. Williams	T. W. M. Long	1,715	7	284
1940	Pinehurst	835	William Allan	Hubert B. Haywood	M. D. Hill F. Webb Griffith	T. W. M. Long .	1,605	8	313
				F. Webb Griffith	Frank C. Smith D. W. Holt	T. W. M. Long T. W. M. Long(1)	1,661	7	311
1941	Pinehurst	755	Hubert B. Haywood		T. C. Kerns	I. H. Manning	1,700	7	309
1942	Charlotte	710	F. Webb Griffith	James W. Vernon	Thos. DeL. Sparrow T. L. Carter George S. Coleman	Roscoe D. McMillan	1,837	8	350
1943	Raleigh	736	Donnell B. Cobb	Paul F. Whitaker	Julian Moore Fred C. Hubbard	Roscoe D. McMillan	1,919	8	361
1944	Pinehurst	760	James W. Vernon	rau F. Whitaker	George L. Carrington	Roscoe D. McMillan	1,982	8	363
1945	No meeting because of O.D.T.		Don't C Whiteless	Oven Maore	Wm. H Smith				
1040	restrictions	000	Paul F. Whitaker Oren Moore	Oren Moore	Zack D. Owens Wm. H. Smith‡	Roscoe D. McMillan	1,811	7	383
1946	Pinehurst	889	Wm M. Coppridge	Frank A. Sharpe	Zack D. Owens G. E. Bell	Roscoe D McMillan Roscoe D. McMillan	1,939 2,191	6 7	397 404
1947	Virginia Beach, Va.	920	Frank A. Sharpe(2)	James F. Robertson	J. B. Bullitt V. K. Hart	100000 27 33033333	5,202	,	10.
1948	Pinehurst	998	James F. Robertson	G. Westbrook Murphy	J. G. Raby Joseph J. Combs	Roscoe D. McMillan	2,298	8	407
1949	Pinehurst				Joseph A. Elliott	Roscoe D. McMillan	2,318	5	405
1950	Pinehurst	947	G.Westbrook Murphy	Roscoe D. McMillan	Ben F. Royal Joseph A. Elliott	Millard D. Hill	2,283	5	455
1951	Pinehurst	938	Roscoe D. McMillan	Frederic C. Hubbard	Joseph A. Elliot Henderson Irwin	Millard D. Hill	2,341	5	469
1952	Pinehurst	969	Frederic C. Hubbard	J. Street Brewer	Forest M. Houser Arthur Daughtridge.	Millard D. Hill	2,326	5	476
1953	Pinehurst	1016	J. Street Brewer	Joseph A. Elliott	George W. Faschal John R. Bender	Millard D. Hill	2,673	5	486
1954	Pinehurst	1077	Joseph A. Elliott	Zack D. Owens	John F. Foster Julian A. Moore	Millard D. Hill	2.801	6	486
1955	Pinehurst	991	Zack D. Owens	J. P. Rousseau Donald B. Koonce	George W. Paschal, Jr. Elias S. Faison E. W. Schoenheit	Millard D. Hill	2,896	6	507
1956	Pinehurst	1022	James P. Rousseau.	Edward W.Schoenheit	Milton S. Clark John S. Rhodes	Millard D. Hill	3,058	7	561
11957	Asheville	867	Donald B. Koonce		O. Norris Smith	Millard D. Hill	3,127	8	522
1958	Asheville	781	Edw. W. Schoenheit	Lenox D. Baker	George W. Holmes Amos N. Johnson	Millard D. Hill	3,171	9	542
1959	Asheville	651	Lenox D. Baker	John C. Reece	Amos N. Johnson Kenneth B. Geddie	John S. Rhodes	3,211	10	251
11960	Raleigh	848	John C. Reece	Amos N. Johnson	Charles M. Norfleet, Jr. W. Walton Kitchin.	John S. Rhodes	3,247	12	472
1961	Asheville	636	Amos N. Johnson	Claude B. Squires	Theodore S. Raiford Charles T. Wilkinson	John S. Rhodes	3,248	12	438
1962	Raleigh	745	Claude B. Squires	John R. Kernodle.	John A. Payne, III J. Sam Holbrook	John S. Rhodes	3,339	9	425
1963	Asheville	714	John R. Kernodle	John S. Rhodes	H Fleming Fuller Jacob H. Shuford	Charles W. Styron	3,491	9	431
1964	Greensboro	677	John S. Rhodes	T. S. Raiford	Wm. F. Hollister F. G. Patterson	Charles W. Styron	3,473	8	398
1965	Charlotte		T. S. Rainford	George W.Paschal,Jr.	Hubert McN. Poteat Wayne J. Benton	Charles W. Styron	3.516	8	390

tDied during his term of office; succeeded by E. J. Wood, first vice president Died during term of office; succeeded by I. H. Manning. (2) Died during term of office; succeeded by James F. Robertson, president-elect.

1932-1965 YEARS FOR COUNTIES BYMEMBERSHIP SOCIETY 0.5 STATUS

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STATUS OF MEMBERSHIP BY COUNTIES-Continued

1965	į	11 7 38	73 4 15	1 297	4	11 46 15	25 31 20 53 31	63 19 18	25 5	39 15	17 15 192 4	12 56	19		3,566
1964		11 7 35	74	2 22	4	11 46 16	32 13	60 25 119	27	38	19 189 6	12 13	119		3,515
1963		10 7 37	81 3 16	27		1252	8888	25 25 17	(c) (c)	527	19 17 188 6	11 18	8 ==		3,429
1962		32 82	79 3	25 cm		127	2423	19 19 19	27	24.8	182	11	138		3,351
1961	1	3.8	80 3 15	: e ≈		222	866 FF	17 25 25 17	27	39	16 173 8	10	× 27	1 1 1 1 1 1 1 1	3,322
1960		13 7	80	26		===	22 84 88 88	63 17 14	28	37	15 15 165 8	9	17 40		3,247
1959		10 7 32	76 4 12	26		100	8224	63 27 17 16	27	38	15 16 159 7	9	238		3,211
1958		318	77	4 28		10 410	2008	25 13 13	27	38	158 158 8	10	39		3,171
1957		11 32	76	29		041	19 19 43	27 27 19 13	29	35	17 16 156 8	10	38.5		3,127
1956		9 10 34	73	28		0.843	28233	2000 1400 1400 1400	29	08	155 155 9	11 42	20		3,058
1955		9 11 35	69	5 27		⊕ 4 α	822.48	25 19 19	29	28	15 15 147 9	68	1		2,896
1954		33 11	88 401	25		0040	4848	24211	56	88 01	152 152 8	37	18		2,801
1953		10 10 20 80	59 01	27		0 45	88848	255 17 145	52	28	117	14	17		2,673
1952		10 11 26	63	26		0 2 4	22,824,8	252 18 18	24	23	112	88	17 30		2,326
1921		101	56 11	4 %	e1	33.7	20 15 45	21 15 13	22	29	1126 126 6	37	19		2,343
1950		10 11 28	56	20		318	25.25	24 15 13	22	29	15 11 120 6	37	18		2,278
1040		13	59	4 91		965	15 47 47 47 47 47 47 47 47 47 47 47 47 47	24.01 17.44.00	26	32	14 112 114 6	37	35		2,318
1948		10 28	62 40	+ 12		32.0	16 47 47	25.4 16.5 16.5 16.5 16.5 16.5 16.5 16.5 16.5	26	31	14 108 108 5	88	17		2,298
1947		7-4-62	33 10	4 71		31	100	24.2 1.4.2 1.5.1	21	29	114 110 110 6	, , , , oc	17 33		2,191
1946		ro 41 ts	± 0 €1 80	4 9		1		24.29 14.00 16.00 16.00	18	7	113	1 1	<u> </u>		1,939
1945		850	04∞	2 3	2	32	3865	34255	16	101	80 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	212	14		1,811
1944		7-4-2	£4.∞	4 61	21	31.00		161816	- 11	27	11 00 00 00 00 00		-		1,982
1943		212	4.4.00	E E				12 23 3	_ ! !	233	110 10 98	20.20	31		1,919
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1933	00	18	25	4 21	-	7-41	10 10 23 23	11022		3 5	10 8.7.8 5	1	- 1	- :	1,363
1932		64		*	=-	20	4.000	33.7	13	7	98	_ ! !	10	*	1,559 1,363
COUNTY	fitchell-Avery 13	fitchell-Yancay	ash 16. ew Hanover. orthampton. nslow	range 17 amilco asquotank-Camden- Currituck-Dare	Asquotank-Camden- Dare 8	erquimans 18itt.	andolph ichmond obeson	oekugnam owan-Davie utherford ampson cotland	tanly 15 tanly-Montgomery tokes	urry 19 urry-Yadkin wain 10 ransylvania		Vashington-Tyrrell 11 Vatauga 21 Vatauga-Ashe 22	Vilkes 2. Vilkes-Alleghany.	adkin 19	Totals

(1) See Iredell-Alexander. (2) See Wilkes-Alleghany. (3) See Watauga-Ashe and Ashe-Watauga. (4) See Mitchell-Avery. (5) See Pasquotank-Candien-Dare and Pasquotank-Candien-Dare. (6) See Alexance-Caswell. (7) See Macon-Clay. (8) See Asquotank-Candien-Dare. (9) See Rowan-Davie. (10) See Jackson-Swall. (11) See Martin-Washington-Tyrrell. (12) See Mitchell-Avery. Mitchell-Watauga, and Mitchell-Yaneey. (13) See Avery and Mitchell. (14) See Mitchell. Watauga-Ashe. (18) See Sanjy-Montgomery, Montgomery, and Stanly. (16) See Edgecombe-Nash. (17) See Durham-Orange. (18) See Chowan-Perquimans. (19) See Surry-Yadkin. (20) See Washington-Tyrrell and Martin-Washington-Tyrrell. (21) See Mitchell-Watauga. (22) See Ashe-Watauga.

ROSTER OF MEMBERS OF NORTH CAROLINA STATE BOARD OF HEALTH FROM ORGANIZATION IN 1877 TO 1965

Name	Address	Appointed by		ern	
S. S. Satchwell, M.D., President					1878
Thomas F. Wood, M.D., Secretary		. State Society	1877		
Joseph Graham, M.D.		State Society	1877		
Charles Duffy, Jr., M.D. Peter E. Hines, M.D.		State Society	1877 1877		
George A. Foote, M.D.			1877		
S. S. Satchwell, M.D., President			1878		
Thomas F. Wood, M.D., Secretary			1878	to	1884
Charles J. O'Hagan, M.D., President		State Society	1878		
George A. Foote, M.D.		State Society	1878		
Marcellus Whitehead, M.D.			1878		
R. L. Payne, M.D.			1878		
H. G. Woodfin, M.D. A. R. Ledeux, Chemist			1878 1878		
William Cain, Civil Engineer			1878		
R. L. Payne, M.D.			1881		
M. Whitehead, M.D., President			1881		
S. H. Lyle, M.D.					1883
William Cain, Civil Engineer			1881	to	1883
W. G. Simmons, Chemist					1883
J. W. Jones, M.D., President			1883		
John McDonald, M.D.					1889
S. H. Lyle, M.D. W. G. Simmons, Chemist			1883 1883		
Arthur Winslow, Civil Engineer			1884		
R. H. Lewis, M.D.			1884		
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1885		
William D. Hilliard, M.D.	Asheville	State Society	1885		
Arthur Winslow, Civil Engineer	Raleigh	Gov. A. M. Scales	1885	to	1893
W. G. Simmons, Chemist			1885		
J. H. Tucker, M.D.			1885		
R. H. Lewis, M.D., Secretary			1887		
H. T. Bahnson, M.D., President Arthur Winslow, Civil Engineer		Gov. A. M. Scales	1887 1887		
W. G. Simmons, Chemist			1887		
J. H. Tucker, M.D.			1888		
J. L. Ludlow, Civil Engineer					1891
J. H. Tucker, M.D.			1888	to	1891
F. P. Venable, Ph.D. Chemist	Chapel Hill		1889		
J. L. Ludlow, Civil Engineer		Gov. D. G. Fowle	1889		
J. A. Hodges, M.D.			1889		
J. M. Baker, M.D. J. H. Tucker, M.D.					1893 1893
F. P. Venable, Ph.D., Chemist		Gov. T. M. Holt			1892
J. L. Ludlow, Civil Engineer		Gov. T. M. Holt			1897
Thomas F. Wood, M.D., Secretary					1895
George G. Thomas, M.D., President	Wilmington	State Board of Health	1892	to	1895
S. Westray Battle, M.D.		State Society	1893		
W. H. Harrell, M.D.			1893		
John Whitehead, M.D.		State Board of Health	1893		
W. H. G. Lucas F. P. Venable, Ph.D., Chemist		Gov. Elias Carr	1893 1893	-	
John C. Chase, Civil Engineer		Gov. Elias Carr	1894		
R. H. Lewis, M.D., Secretary		Gov. Elias Carr	1895		
W. P. Beall, M.D.		Gov. Elias Carr	1895		
W. J. Lumsden, M.D.		Gov. Elias Carr	1895		1897
John Whitehead, M.D.	Salisbury	State Society	1895	to	189
W. H. Harrell, M.D.		State Society	1895		
W. P. Beall, M.D.		Gov. Elias Carr	1895		
R. H. Lewis, M.D., Secretary		Gov. Elias Carr	1897		
F. P. Venable, Ph.D., Chemist		Gov. Elias Carr	1897		1899
John C. Chase, Civil Engineer Charles J. O'Hagan, M.D.		Gov. D. L. Russell	1897 1897		1899
John D. Spicer, M.D.		Gov. D. L. Russell	1897		1899
J. L. Nicholson, M.D.	I	Gov. D. L. Russell	1899		190
R. H. Lewis, M.D., Secretary		Gov. D. L. Russell			190
A. W. Shaffer, Civil Engineer	Raleigh	Gov. D. L. Russell	1899	to	190
Charles J. O'Hagan, M.D.	Greenville	Gov. D. L. Russell	1899		
J. L. Nicholson, M.D.		Gov. D. L. Russell	1899		
Albert Anderson, M.D.			1899		1901
George G. Thomas, M.D., President	(II/ilminoton				

[†] Dled in 1892, leaving a five-year unexpired term, which was filled by the Board

Name	Address	Appointed by	Term
S. Westray Battle, M.D.	Asheville Jackson	State Society	1899 to 1901 1899 to 1901
H. W. Lewis, M.D.		State Society	1901 to 190'
H. H. Dodson, M.D.	Raleigh	Gov. C. B. Aycock	1901 to 190'
R. H. Lewis, M.D., Secretary W. P. Ivey, M.D		Gov. C. B. Aycock	1901 to 190
George G. Thomas, M.D., President	Wilmington	Gov. C. B. Aycock	1901 to 190
Francis Duffy, M.D.	New Bern	Gov. C. B. Aycock	1901 to 190
J. L. Ludlow, Civil Engineer	Winston	Gov. C. B. Aycock	1901 to 190
S. Westray Battle, M.D.			1901 to 190'
H. W. Lewis, M.D.		State Society	1901 to 190'
W. H. Whitehead, M.D.	Rocky Mount	State Society	1901 to 190
J. L. Nicholson, M.D			1901 to 190
J. L. Ludlow, Civil Engineer	Winston	Gov. C. B. Aycock	1903 to 1909
J. Howell Way, M.D.	Waynesville	Gov. R. B. Glenn	1905 to 191
W. O. Spencer, M.D.	Winston	Gov. R. B. Glenn	1905 to 1911
George G. Thomas, M.D., President	Wilmington	State Society	1905 to 191
Thomas E. Anderson, M.D.	Statesville	State Society	1907 to 1913
R. H. Lewis, M.D	Raleigh	Gov. R. B. Glenn	1907 to 1913
E. C. Register, M.D.	Charlotte	Gov. R. B. Glenn	1907 to 1909
David T. Tayloe, M.D.	Washington	State Society	1907 to 1913
James A. Burroughs, M.D.1	Asheville	State Society	1909 to 1913
J. E. Ashcraft, M.D.	Monroe	State Board of Health	1909 to 1913
J. L. Ludlow, Civil Engineer		Gov. W. W. Kitchin	1911 to 191'
J. Howell Way, M.D., President	Waynesville	Gov. W. W. Kitchin	1911 to 191'
W. O. Spencer, M.D.	Winston-Salem		1911 to 191
Thomas E. Anderson, M.D.	Statesville	State Society	1911 to 191'
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1913 to 1919
R. H. Lewis, M.D.	Raleigh	Gov. Locke Craig	1913 to 1919
Edw. J. Wood, M.D.	Wilmington	Fov. Locke Craig	1913 to 191
A. A. Kent, M.D. ²	Lenoir	State Society	1913 to 1919
Cyrus Thompson, M.D.	Jacksonville	State Society	1913 to 1919
Fletcher R. Harris, M.D.	Henderson	State Board of Health	1915 to 192
J. L. Ludlow, Civil Engineer	Warnegville	Gov. Locke Craig	1917 to 1923
J. Howell Way, M.D., President	Charlette	Gov. T. W. Bickett	1917 to 1923
E. C. Register, M.D. ¹ Thomas E. Anderson, M.D	Statosville	State Society	1917 to 1923
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1919 to 1923
Fletcher R. Harris, M.D. ³	Henderson	State Society	1919 to 1923
A. J. Crowell, M.D.	Charlotte	Cov T W Bickett	1921 to 1923
Chas. E. Waddell, C. E.	Asheville	Gov C Morrison	1919 to 192
Cyrus Thompson, M.D.	Jacksonville	State Society	1919 to 192
R. H. Lewis, M.D.	Raleigh	Gov T W Bickett	1923 to 1925
E. J. Tucker, D.D.S.	Roxboro	Gov. T. W. Bickett	1923 to 1929
J. Howell Way, M.D., President	Waynesville	Gov. C. Morrison	1923 to 1929
A. J. Crowell, M.D.	Charlotte	Gov. C. Morrison	1923 to 192'
James P. Stowe, Ph.G.	Charlotte		1923 to 1925
D. A. Stanton, M.D.	High Point	State Board of Health	1923 to 1929
Thomas E. Anderson, M.D.	Statesville	State Society	1923 to 1920
Charles O'H. Laughinghouse, M.D.5			1925 to 193
Cyrus Thompson, M.D.1	Jacksonville	State Society	1925 to 1933
D. A. Stanton, M.D.	High Point	State Society	1925 to 1933
R. H. Lewis, M.D.1	Raleigh	Gov. A. W. McLean	1926 to 193
Jno. B. Wright, M.D.6	Raleigh	Gov. A. W. McLean	1925 to 1933
E. J. Tucker, D.D.S	Roxboro	Gov. A. W. McLean	1926 to 192'
W. S. Rankin, M.D.4	Charlotte	State Board of Health	1927 to 1929
L. E. McDaniel, M.D.	Jackson	State Board of Health	1927 to 1929
Chas. C. Orr, M.D.		Gov. A. W. McLean	1929 to 193
Thomas E. Anderson, M.D. ⁶		State Society	1929 to 193
L. E. McDaniel, M.D.6			1927 to 193
James P. Stowe. Ph.G.6			1929 to 193
A. J. Crowell, M.D. ⁶			1930 to 193
J. M. Parrott, M.D.6			1929 to 193
Chas. C. Orr, M.D.			1931 to 193
J. M. Parrott, M.D.5			1931 to 193
C. V. Reynolds, M.D.			1931 to 1933
L. B. Evans, M.D.			1931 to 193
S. D. Craig, M.D.			1931 to 1933
John T. Burrus, M.D.			1931 to 1933
J. N. Johnson, D.D.S.			1931 to 1933
J. A. Goode, Ph.G.			1931 to 1933
H. L. Large, M.D.			1931 to 193
	(thomal IIII)	Gov. O. Max Gardner	1931 to 193

Died leaving unexpired term.
 Resigned to become member of General Assembly.
 Resigned to become Health Officer Vance County.
 Resigned.

⁵ Resigned to become Secretary of State Board of Health 6 Term terminated on account of the reorganization of the State Board of Health by General Assembly.

Nume	Address	Appointed by	Term
Grady G. Dixon, M.D.	Ayden	Ex. Com. State Society	1931 to 1932
Grady G. Dixon, M.D.			1932 to 1935
S. D. Craig, M.D.			1933 to 1937
W. T. Rainey, M.D.			1933 to 1937
J. N. Johnson, D.D.S.			1933 to 1937
Hubert B. Haywood, M.D.	Raleigh	Gov. J. C. B. Ehringhaus	1933 to 1937
James P. Stowe, Ph.G.			1933 to 1937
Grady G. Dixon, M.D.			1935 to 1939
J. LaBruce Ward, M.D.	Asheville	State Society	1935 to 1939
H. Lee Large, M.D.			1935 to 1939
H. G. Baity, C.E.			1935 to 1939
J. N. Johnson, D.D.S.			1937 to 1941
Hubert B. Haywood, M.D.			1937 to 1941
James P. Stowe, Ph.G.			1937 to 1941
S. D. Craig, M.D.			1937 to 1941
W. T. Rainey, M.D.			1937 to 1941
Grady G. Dixon, M.D.			1939 to 1943
J. LaBruce Ward, M.D.			1939 to 1943
H. Lee Large, M.D.			1939 to 1943
H. G. Baity, Sc.D.			1939 to 1943
C. C. Fordham, Jr., Ph.G.			1940 to 1943
S. D. Craig, M.D.			1941 to 1945
W. T. Rainey, M.D.			1941 to 1945
Hubert B. Haywood, M.D.			1941 to 1945
J. N. Johnson, D.D.S.			1941 to 1945
James O. Nolan, M.D.			1941 to 1945
Grady G. Dixon, M.D. J. LaBruce Ward, M.D.	Ashavilla	State Society	1943 to 1947
			1943 to 1947
H. Lee Large, M.D. Larry I. Moore, Jr.			1943 to 1947
S. D. Craig, M.D., Pres.	Wington Solom	State Society	1943 to 1947 1945 to 1949
W. T. Rainey, M.D.	Favetteville	State Society	1945 to 1949
Hubert B. Haywood, M.D.	Paleigh	Gov B Gregg Cherry	1945 to 1949
James O. Nolan, M.D.	Kannanolis	Gov B Gregg Cherry	1945 to 1949
Paul Jones, D.D.S.9			1946 to 1949
Jasper C. Jackson, Ph.G. ¹⁰			1945 to 1947
Grady G. Dixon, M.D., Pres.	Ayden	State Society	1947 to 1951
H. Lee Large, M.D.	Rocky Mount	Gov R Gregg Cherry	1947 to 1951
J. LaBruce Ward, M.D.		State Society	1947 to 1951
Hubert B. Haywood, M.D.			1949 to 1953
Mrs. James B. Hunt	Lucama	Gov. W. Kerr Scott	1949 to 1953
A. C. Current, D.D.S.	Gastonia	Gov. W. Kerr Scott	1949 to 1953
John R. Bender, M.D.	Winston-Salem	State Society	1949 to 1953
Benjamin J. Lawrence, M.D.		State Society	1949 to 1953
G. Grady Dixon, M.D.	Avden		1951 to 1955
George Curtis Crump, M.D.		Medical Society	1951 to 1955
John P. Henderson, Jr., M.D.11			1954 to 1955
H. C. Lutz, Phg.	Hickory	Gov. W. Kerr Scott	1951 to 1955
Hubert B. Haywood, M.D.12	Raleigh	Gov. Wm. Umstead	1953 to 1957
Mrs. J. E. Latta		Gov. Wm. Umstead	1953 to 1957
A. C. Current, D.D.S.	Gastonia		1953 to 1957
John R. Bender, M.D.			1953 to 1957
Benjamin J. Lawrence, M.D.		Medical Society	1953 to 1957
G. Grady Dixon, M.D.15		Medical Society	1955 to 1959
George Curtis Crump, M.D.12		Medical Society	1955 to 1959
Roger W. Morrison, M.D.14		Medical Society	1957 to 1957
John P. Henderson, Jr., M.D.		Gov. Luther H. Hodges	1955 to 1959
H. C. Lutz, Phg.		Gov. Luther H. Hodges	1955 to 1959
Lenox D. Baker, M.D.13	Durham	Gov. Luther H. Hodges	1956 to 1957
Earl W. Brain, M.D.16	Raleigh	Medical Society	1958 to 1959
Mrs. J. E. Latta		Gov. Luther H. Hodges	1957 to 1961
Roger W. Morrison, M.D.		Medical Society	1957 to 1959
John R. Bender, M. D.	Winston-Salem	Medical Society	1957 to 1961
Z. L. Edwards, D.D.S.	Washington	Gov. Luther H. Hodges	1957 to 1961
Chas. R. Bugg, M.D., Pres. 17	Raleigh	Medical Society	1957 to 1961
Lenox D. Baker, M.D.	Durham	Gov. Luther H. Hodges	1957 to 1961

11 To fill vacancy caused by the death of Dr. H. Lee Large.
12 Resigned
13 To fill vacancy caused by resignation of Dr. Hubert B. Havwood.
14. To fill vacancy caused by resignation of Dr. George Curtis Crump
15 Died leaving unexpired term.
16 To fill vacancy caused by the death of Dr. G. Grady Dixon.
17. Died leaving unexpired term.

⁷ To fill vacancy caused by resignation of Dr. J. M. Parrott.
8 To fill vacancy caused by the death of James P. Stowe, Ph.G.
9 To fill vacancy caused by resignation of J. N. Johnson, D.D.S.
10 To fill vacancy caused by resignation of Larry I. Moore, Jr.

Name	Address	Appointed by		Term		
Ben W. Dawsey, D.V.M.	Gastonia	Gov. Luther H. Hodg	es	1959	to	1963
Rogert W. Morrison, M.D.	. Asheville	Medical Society		1959	to	1963
Jasper C. Jackson, Phg	Lumberton (Gov. Luther H. Hodge	es	1959	to	1963
Oscar S. Goodwin, M.D.	Apex	Medical Society		1959	to	196
*Chas. R. Bugg, M.D., Pres	Raleigh	Medical Society		1961	to	196
Lenox D. Baker, M.D.	.Durham	Gov. Terry Sanford .		1961	to	196
D. T. Redfern	. Wadesboro	Gov. Terry Sanford .		1961	to	196
Glenn L. Hooper, D.D.S.				1961	to	196
John R. Bender, M.D.	Winston-Salem 1	Medical Society		1961	to	196
John S. Rhodes, M.D.18	Raleigh	Medical Society		1963	to	196
S. G. Koonce	Chadbourn	Gov. Terry Sanford		1963	to	196
James S. Raper, M.D.	Asheville	Medical Society		1963	to	196
Ben W. Dawsey, D.V.M.	Gastonia	Gov. Terry Sanford		1963	to	196
Joseph S. Hiatt, Jr., M.D.	Southern Pines	Medical Society		1965	to	196
Howard Paul Steiger, M.D.	Charlotte Medical Society 1	Medical Society		1965	to	196

18. Fill vacancy caused by death of Dr. Chas. R. Bugg.

ROSTER OF MEMBERS OF THE VARIOUS BOARDS OF MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA

NORTH CAROLINA						
FIRST BOARD		SIXTH AND SEVENTH BOARD	S_3			
James H. Dickson, Wilmington Charles E. Johnson, Raleigh Caleb Winslow, Hertford	1859-1866 1859-1866	R. L. Payne, Jr., Lexington George W. Purefoy, Asheville George G. Thomas, Wilmington	.1890-1892 .1890-1894			
Otis F. Manson, Townsville William H. McKee, Raleigh Christopher Happoldt, Morganton J. Graham Tull, New Bern	1859-1866 1859-1866	Robert S. Young, Concord William H. Whitehead, Rocky Mount George W. Long, Graham L. J. Picot, Secretary, Littleton	.1890-1896 .1890-1896			
Samuel T. Iredell, Secretary SECOND BOARD	1859-1866	Julian M. Baker, Tarboro H. B. Weaver, Secretary, Asheville J. M. Hays, Greensboro ⁴	1892-1898 1892-1898 1894-1897			
N. J. Pittman, Tarboro E. Burke Haywood, Raleigh		Kemp P. Battle, Jr., Raleigh ⁵ Thomas S. Burbank, Wilmington ¹ Richard S. Whitehood, Changl Hill ⁴	1894_1898			
R. H. Winborne, Edenton S. S. Satchwell, Rocky Point J. J. Summerell, Salisbury	1866 - 1872 $1866 - 1872$	Richard S. Whitehead, Chapel Hill ⁴ William H. H. Cobb, Goldsboro ⁶ J. Howell Way, Secretary, Waynesville ⁷ David T. Tayloe, Washington	1898-1902			
R. B. Haywood, Raleigh M. Whitehead, Salisbury J. F. Shaffner, Salem	1866-1872 1866-1872 1866-1872	Thomas E. Anderson, Sec., Statesville Albert Anderson, Wilson ⁸ Edward C. Register, Charlotte ⁸	1896-1902 1896-1902 .1898-1902			
William Little, Secretary Thomas F. Wood, Secretary, Wilmington	1866 - 1872	Thomas S. McMullan, Hertford ⁸ John C. Walton ⁸	.1900-1902			
THIRD BOARD		EIGHTH BOARD				
Charles J. O'Hagan, Greenville W. A. B. Norcom, Edenton C. Tate Murphy, Clinton George A. Foote, Warrenton J. W. Jones, Tarboro R. L. Payne, Lexington Charles Duffy, Jr., Secretary, New Bern	1872-1878 1872-1878 1872-1878 1872-1878 1872-1878	A. A. Kent, Lenoir Charles O'H. Laughinghouse, Greenville M. H. Fletcher, Asheville James M. Parrott, Kinston J. T. J. Battle, Greensboro Frank H. Russell, Wilmington George W. Pressly, Secretary, Charlotte ¹ G. T. Sikes, Secretary, Grissom ⁹	. 1902-1908 1902-1908 1902-1908 1902-1908 1902-1908 1902-1906			
FOURTH BOARD		NINTH BOARD				
Peter E. Hines, Raleigh Thomas D. Haigh, Fayetteville George L. Kirby, Goldsboro Thomas F. Wood, Wilmington Joseph Graham, Charlotte Robert I. Hicks, Williamston ¹ Richard H. Lewis, Raleigh ² Henry T. Bahnson, Secretary, Salem	.1878-1884 .1878-1884 .1878-1884 .1878-1884 .1878-1880 .1880-1884	Lewis B. McBrayer, Asheville John C. Rodman, Washington William W. McKenzie, Salisbury Henry H. Dodson, Greensboro John Bynum, Winston-Salem J. L. Nicholson, Richlands Benj. K. Hays, Secretary, Oxford	.1908-1914 .1908-1914 .1908-1914 .1908-1914 .1908-1914			
	.1010-1004	TENTH BOARD				
FIFTH BOARD William R. Wood, Scotland Neck Augustus W. Knox, Raleigh Francis Duffy, New Bern Patrick L. Murphy, Morganton Willis Alston, Littleton J. A. Reagan, Weaverville W. J. H. Bellamy, Secretary, Wilmington	.1884-1890 .1884-1890 .1884-1890 .1884-1890	Isaac M. Taylor, Morganton John Q. Myers, Charlotte Jacob F. Highsmith, Fayetteville Martin L. Stevens, Asheville Charles T. Harper, Wilmington ⁴ Edwin G. Moore, Elm City ¹⁰ John G. Blount, Washington ¹¹ Hubert A. Royster, Secretary, Raleigh				

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ELEVENTH BOARD	
Lester A. Crowell, Lincolnton William P. Holt, Duke J. Gerald Murphy, Wilmington Lucius N. Glenn, Gastonia Clarence A. Shore, Raleigh William M. Jones, Greensboro Kemp P. B. Bonner, Sec., Morehead City	1920-1926
TWELFTH BOARD	
Paul H. Ringer, Asheville W. Houston Moore, Wilmington T. W. M. Long, Roanoke Rapids W. W. Dawson, Grifton ⁴ J. K. Pepper, Winston-Salem Foy Roberson, Durham John W. McConnell, Secretary, Davidson David T. Tayloe, Jr., Washington ¹²	1926-1932 1926-1932 1926-1932 1926-1930 1926-1932 1926-1932 1926-1932 1930-1932
THIRTEENTH BOARD	
Ben F. Royal, Morehead City Benj. J. Lawrence, Secretary, Raleigh F. Webb Griffith, Asheville Hamilton W. McKay, Charlotte J. W. Vernon, Morganton W. H. Smith, Goldsboro K. G. Averitt, Cedar Creek [‡] Roscoe D. McMillan, Red Springs ¹³	1932-1938
FOURTEENTH BOARD	
Karl B. Pace, Greenville William M. Coppridge, Durham Frank A. Sharpe, Greensboro Lewis W. Elias, Asheville ⁴ J. Street Brewer, Roseboro W. D. James, Secretary, Hamlet L. A. Crowell, Jr., Lincolnton John LaBruce Ward, Asheville ¹⁴ FIFTEENTH BOARD	.1938-1944 .1938-1944 .1938-1943 .1938-1944
C. W. Armstrong, Salisbury	1944-1950
Paul G. Parker, Erwin M. D. Bonner, Jamestown T. Leslie Lee, Kinston Roy B. McKnight, Charlotte M. A. Pittman, Wilson Ivan M. Procter, Secretary, Raleigh James B. Bullitt, Chapel Hill ¹⁵ Paul F. Whitaker, Kinston ¹⁶	. 1944-1950 . 1944-1950 . 1944-1950
SIXTEENTH BOARD	
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1 Resigned before expiration of term. 2 Elected for unexpired term of Dr. Hicks. 3 In 1890 the Medical Society of the State of North Carolina adopted the plan of electing members of the Board in such a manner that the terms would expire at different intervals of two years. This practice was followed for twelve years, or until 1902, when the plan was abandoned; an equivalent of two terms of six years each. It is evident that the Society arranged to abandon the policy as early as 1898, as two members were elected for short terms, and two years later two other members were elected for still shorter terms. It is therefore impossible to separate the sixth and seventh Boards, since the membership was overlapping. 4 Died before the expiration of his term. 5 Elected to serve unexpired term of Dr. Hays. 6 Elected to serve the unexpired term of Dr. Burbank. 7 Elected to serve the unexpired term of Dr. Whitehead. 8 Elected for short term expiring in 1902. 9 Elected to serve the unexpired term of Dr. Harper. 10 Died a few months before the expiration of his term; such a short time that the vacancy was not filled. 12 Elected to serve unexpired term of Dr. W. W. Dawson. 13 Elected to serve unexpired term of Dr. Averitt. 14 Elected to serve unexpired term of Dr. T. Leslie Lee. 16 Elected to serve unexpired term of Dr. Paul G. Parker. 17 Elected to serve unexpired term of Dr. James P.
Rousseau. MEDICAL AWARDS
MOORE COUNTY MEDICAL SOCIETY MEDAL In 1927 the Moore County Medical Society estab-
lished a fund, the interest from which is used to pay for a medal to be given for the best paper read at the State Society meeting each year. No one is eligible to receive this medal except Fellows of the Medical Society of the State of North Carolina in good standing; no invited guest is allowed to compete. Each Section Chairman selected a committee of
three to decide on the best paper written in their section. The winning papers are then turned over to the State Committee, who select the one to receive
the medal. The following Fellows have been awarded this medal: 1928—Paul Pressly McCain, M.DSanatorium
"The Diagnosis and Significance of Juvenile Tuberculosis" (From the Section on Pediatrics)
1929—A. B. Holmes, M.D. Fairmont "The Treatment of Uremia"
(From the Section on Chemistry, Materia Medica and Therapeutics)
1930—C. T. Smith, M.D., and W. Bernard Kinlaw, M.D. Rocky Mount "The Clinical Consideration of Anemia of Pregnancy and of Puerperium"
(From Section on Practice of Medicine) 1931—F. C. Smith, M.D
(From Section on Eye, Ear, Nose and Throat) 1932—Charles I. Allen, M.D
1933—H. L. Sloan, M.D

1954—Paul Kimmelstiel, M.D. Charlotte Roland T. Pixley, M.D. Charlotte John Crawford, M.D. Charlotte
"Statistical Review of Twenty-two Thousand Cases Examined by Cervical Smears" (From Section on Pathology)
1955—H. Hugh Bryan, M.D
(From Section on Public Health) 1956—Wm. M. Peck, M.D
1957—John R. Ashe, Jr., M.D
1958—John O. Lafferty, M.D.
"Peptic Ulcers in Children"
(From Section on Radiology) 1959—Robert E. Coker, Jr., M.DChapel Hill "The Medical Student and Specialization" (From Section on Public Health & Education)
"Management of Childhood Nephrosis" (From Section on Pediatrics)
1961—William W. Shingleton, M.D
Tracts and Pancreas" (From Section on Surgery) 1962—Frank C. Greiss, Jr., M.DWinston-Salem "Inevitable, Incomplete and Septic Abortions"
(From Section on Obstetrics & Gynecology) 1963—No Awards. 1964—Christopher Columbus Fordham, III, M.D
"Problems in the Diagnosis of Renal Parenchyma Disease" (From Section on General Practice of
Medicine) THE GEORGE MARION COOPER AWARD
The Fellows of the Wake County Medical Society present
This medal is awarded by the Fellows of the Wake County Medical Society as a token of appreciation and esteem in recognition of the eminence of an essay contributing to the knowledge and advance-
ment of the science of medicine in the field of Preventive Medicine, Public Health, or Maternal and Infant Health Care, presented before the Medi- cal Society of the State of North Carolina. The
following Fellows have been awarded this medal: 1951—Donald L. Whitener, M.DWinston-Salem "The Management of Labor and Delivery in the Interest of the Premature Infant"
(From Section on Gynecology and Obstetrics) 1952—Ronald Stephen, M.D., Senior Author; Duke UniversityDurham "The Evaluation of Methods of Pain Relief
During Labor and Delivery with Reference to Mother and Child" (From Section on Gynecology and Obstetrics)
1953—Ernest Craige, M.D
1954—Richard L. Pearse, M.D. Durham Eleanor Easley, M.D. Durham
Kenneth Podger, M.D. Durham "Obstetric Analgesia and Anesthesia" (From Section on Obstetrics and Gynecology)

1955—Dirk Verhoeff, M.D. Huntersville William M. Peck, M.D. McCain "The Trends in Management of Tuberculosis in Children" (From Section on Pediatrics) 1956—Benjamin A. Johnson, M.D. Durham Susan C. Dees, M.D. Durham "Immunization of Allergic Children with Particular Reference to Eczema Vaccinatum" (From Section on Pediatrics)	should take note of this in the preparation of the 1956 program and in judging of presentations at the Annual Session in 1956. The following Fellows have been awarded this medal. 1952—Kenneth L. Pickrell, M.D. Durham "Tattooing the Cornea" (From Scientific Exhibits) 1953—Joseph E. Markee, M.D. Durham "Autonomic Nervous System" (Film from Audio-Visual Postgraduate
(From Section on Pediatrics) 1957—Walter A. Sikes, M.D. Raleigh John D. Patton, M.D. Asheville Robert L. Craig, M.D. Asheville Marie Baldwin, M.D. Asheville Anne Sagberg, M.D. Asheville R. Charman Carroll, M.D. Asheville "Trends in the Development of an Open Psychiatric Hospital" (From Section on Neurology and Psychiatry)	Instructional Program) 1954—William H. Boyce, M.D. Winston-Salem Fred K. Garvey, M.D. Winston-Salem Charles M. Norfleet, M.D. Winston-Salem "Biocolloids of Urine in Health and in Calculous Disease" (From Scientific Exhibits) 1955—Caleb Young, M.D. Winston-Salem "Congenital Dislocation of the Hip" (A motion picture)
1958—Madison S. Spach, M.D. Jerome S. Harris, M.D. "Congenital Heart Disease in Infancy" (From Section on Pediatrics"	(From Postgraduate Audio-Visual Program) 1956—C. R. Stephen, M.D. Durham R. C. Martin, M.D. Durham Bourgeois-Gavardin. Durham
1959—Roy T. Parker, M.D. Durham Harry W. Johnson, M.D. Durham F. Bayard Carter, M.D. Durham "Obstetric Shock" (From Section on General Practice of Medicine)	"Prophylaxis of Non-Hemolytic Transfusion Reactions: Value of Pyribenzamine" (From Section on Anesthesia) 1957—J. Leonard Goldner, M.D
1960—Courtney D. Egerton, M.D. Raleigh Robert J. Ruark, M.D. Raleigh "Continuous Caudal Analgesia in Private Practice"	"The Juvenile Amputee-Upper Extremity" (From Section on General Practice of Medicine) 1958—T. Franklin Williams, M.D. J. L. DeWalt, M.D.
(From Section on Obstetrics & Gynecology) 1961—Kenneth D. Hall, M.D	R. W. Winter, M.D. Charles H. Burnett, M.D. "Newer Diagnostic Criteria in Hyperparathy- roidism" (Fig. Criteria: Fubility)
1962—Jesse P. Chapman, Jr., M.D Asheville "Thoracic Trauma and Its Treatment" (From Section on Orthopaedics and Traumatology)	(From 1958 Scientific Exhibits) 1959—Albert G. Smith, M.D
1963—No Awards. 1964—Robert Stevenson Lackey, M.D Charlotte "Special Procedures in a Community Hospital" (From Section on Radiology)	1960—Paul W. Sanger, M.D
GASTON COUNTY MEDICAL SOCIETY AWARD By authority of the House of Delegates an award	"Tumor Formation" (1961 Scientific Exhibits) 1962—Paul W. Sanger, M.D
is established by the Gaston County Medical Society for the best presentation of audio-visual material in scientific treatise and will be awarded to the	Presentation of New Methods" (1962 Scientific Exhibits) 1963—No Awards.
best presentation annually at the Annual Session of the State Society. Competition will be restricted to audio-visual material as provided by the rules. Pro- gram Chairmen of the eleven scientific sections	1964—Joseph William Eades, M.D. Greensboro Hilliard Foster Seigler, M.D. Greensboro "Hand Rehabilitation Center" - Chapel Hill (1964 Scientific Exhibits)







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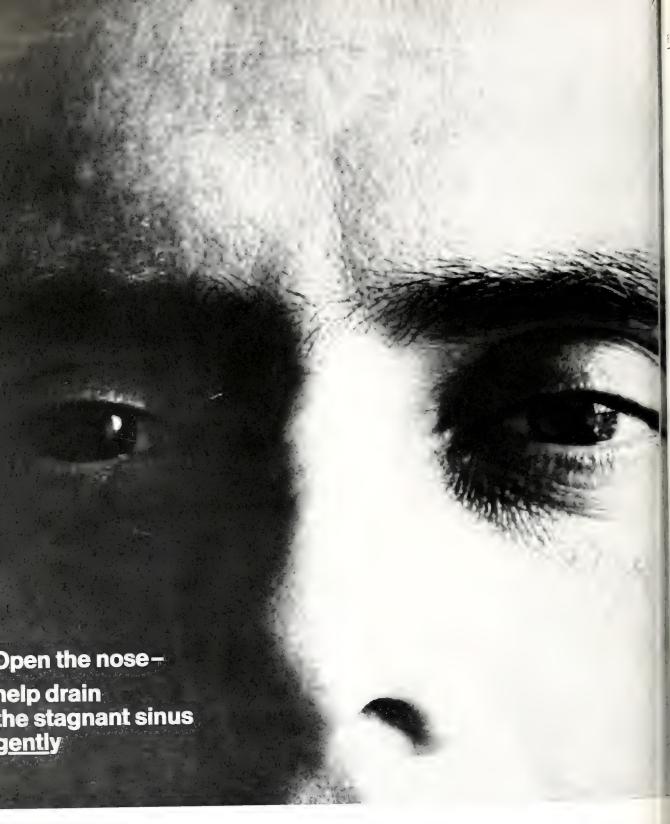
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Chemotherapy with Mastectomy for Cancer of the Breast MEGELV

H. MAX SCHIEBEL, M.D.

MAR 1 1966

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Combined Adjuvant Chemotherapy with Radical Mastectomy for Carcinoma of the Breast

H. MAX SCHIEBEL, M.D. DURHAM

Although cancer of the breast is one of the oldest recorded malignant lesions, if not the oldest, it remains at the top of our cancer problems today. There are three major reasons for this fact:

- 1. There are no known means of prevention such as apply in some other areas.
- 2. Its incidence is not decreasing. There are 60,000 new cases with 24,000 reported deaths each year.
- 3. Seventy years of unparalleled interest and study have produced a staggering volume of literature but have had little effect on the recurrence and mortality.

Innumerable statistical studies based on different premises as to operability, follow-up, lost cases, and deaths due to other causes have often been more confusing than helpful.

The over-all improvement rate of approximately 8 to 10 per cent in the treatment of cancer of the breast since the classical presentations of the techniques and results of Halstead¹ and Meyer has been due to a (1) reduction of the immediate mortality by such factors as avoidance and control of sepsis, the distribution of competently trained surgeons, the availability of blood, etc.;² and (2) to more critical selection of cases for operation.

Selection of Cases for Surgery

Indications for surgery range from the strict criteria of Haagensen,³ which reduce operability to about 50% of all patients, to the loose and unwarranted practice of operating upon every patient encountered. However, having seen such patients as a

Read before the North Carolina Surgical Association,

October 1, 1965

pregnant woman, aged 37, with cancer of the breast and axillary metastasis living and free of metastasis 21 years following radical mastectomy and radiation, I think a

For editorial comment see page 81

rigid attitude toward operability unjustifiable. I agree with such authors as Taylor,⁴ Welch,⁵ and Adair⁶ that those who adopt a laissez faire attitude are in error, and that we are obligated to offer some benefit of doubt to those patients who may be salvageable. Adair⁶ stated that "we consider any case operable in which the disease is localized to the breast or to the breast and axilla, and in which we consider there is a chance of cure, no matter how small that chance."

Why Recurrences?

If we knew the reasons for recurrence, hope of solving the problem would be greatly enhanced. Various reasons have been given through the years, and the emphasis has changed from time to time. For example, skin recurrence in the chest wall has been ascribed to flaps cut too thick, leaving lymphatic vessels containing cancer cells in the local area; or to cells left there by careless handling of the biopsy specimen; or to inadequate removal of skin surrounding the tumor mass. I submit that I have noted various surgeons using a wide variety of skin thicknesses and skin margins with very little difference in the skin recurrence rate. Repeated observers have recovered isolated or clumped cancer cells from wound washings. Lymph nodes left beyond the margins of resection and then spreading or allowing cells to pass through this filter to other areas have recently been re-emphasized by Kennedy and others.⁷

Host resistance in the face of recurrences varies intensely. The following case emphasizes this point.

Case 1

A 59-year-old woman was admitted to Watts Hospital on September 20, 1958, because of a 1.5-cm mass noted in the upper lobe of the left lung. The past history of any importance included a radical mastectomy (right) for adenocarcinoma of the breast in June, 1943, and an old history of pulmonary tuberculosis in 1917. The medical consultant thought that the mass most likely represented a reactivation of tuberculosis. All sputum and gastric washings were negative. A therapeutic trial of INH and PAS was instituted. Four months later there had been no improvement.

An exploratory thoracotomy was performed on January 28, 1959, with a preoperative diagnosis of carcinoma of the lung. The mass was found to be a lymph node attached to and invading the bronchial wall. A left upper lobectomy with dissection of the hilar nodes was performed. The bronchial wall and all hilar nodes contained metastatic carcinoma, probably originating in the breast. The patient has remained entirely well and was last seen on Sept. 12, 1965.

Significance of Cancer in the Blood Stream

Much work has been carried out clinically and in the laboratory to show that cancer cells may circulate in the blood stream before, during, and after surgery. Roberts and others⁸ have shown that the presence of cells in a blood sample does not necessarily mean metastasis. However, the presence of a shower of cancer cells during the operative procedure is associated with a five-year survival rate of only one-half that of patients with negative blood samples during operation.

Watne and associates,⁹ in an 18-month follow-up, found a 54% survival rate in patients who had cancer cells in the circulating blood, compared to 71% in those who did not. Engell,¹⁰ on the other hand, saw no significant difference between the survival rates of the two groups, and concluded that in a majority of cases, tumor cells circulating in the blood before and during operation must have perished.

In a study of 133 patients with cancer

of the breast, Candar and others¹¹ showed that when only a single blood sample was drawn for examination, tumor cells were found in only 42% of the cases; but when several samples were taken, this figure rose to 56%. In sharp contrast, when an additional 20 patients were studied on the basis of multiple samples, the percentage rose to 80%. Finally, 10 patients were studied on the basis of a single large sample consisting of 100 ml of blood. In this group the percentage of positive cases reached 90%. Five of these patients had axillary nodes that were found to be positive for tumor cells; in the other five the nodes were negative. Candar concluded that if enough samples were studied and if the samples were large enough, the positive yield would approach 100%. However, of 98 patients in whom cancer cells were found in the circulating blood by the use of only one sample, 61% had positive axillary nodes as opposed to 39% who did not. This finding would suggest that the more extensive the disease. the greater the number of cells shed into the circulating blood. Many observers have noted that lymph node involvement is found more frequently in association with the larger primary lesions.

It is possible from these somewhat conflicting conclusions to become confused and say that the presence of cancer cells in the blood stream is not important in predicting whether or not hematogenous metastasis will develop. On sober thought, however, one must recognize that if cancer cells were never present in the blood, hematogenous metastasis could not arise. Horsley¹² has emphasized this point and bases his advocacy of concomitant castration upon it.

The number of circulating cancer cells present may really be significant. McDonald and Cole¹³ have shown that in animals the percentage of cancer "takes" rises sharply and beyond arithmetic proportion with an increase in the number of cancer cells injected into the peripheral blood.

Very recently Robinson¹⁴ demonstrated ingeniously the effect of local trauma and ischemia on the development of blood-borne metastasis. He used three equal groups of

rabbits, all under anesthesia. In one group the femoral vessels on one side were ligated; in the second group controlled blunt trauma was applied repeatedly to the thigh muscles on one side for one minute; the third group served as complete controls for the first two.

One million cells of Rabbit V₂ carcinoma were injected into the aorta through a polyethylene catheter. In addition to comparison with a complete control group, a damaged limb could be compared to the opposite undamaged limb of the same animal. In both the animals with the traumatized limbs and those with ligated femoral vessels, the number of metastases was three to four times greater than in the controls. Despite our best efforts, a radical mastectomy always results in local trauma and a damaged blood supply.

What Have We Done to Prevent Recurrence?

For many years, in attempting to prevent recurrences, the emphasis was placed on more radical surgery and better techniques. For a complete review of the advances in this field, I would recommend the excellent articles by Trimble¹⁵ and Artz¹⁶ and the monographs by Haagensen³ and Lewison.¹⁷ Garside¹⁸ has appropriately noted that any standard procedure or reasonable modification thereof that the surgeon is most familiar with is *adequate*, provided the emphasis is placed on meticulous handling of tissue. One should think about "cancer asepsis and cancer contamination" the same as one would of their bacterial counterparts.

Radiation was the next step in the effort to prevent recurrence—in other words, to destroy cancer cells left at the time of operation. Radiation has been a most valuable tool, and has been used in varying degrees preoperatively, postoperatively, separately, and combined. According to several large surveys, a majority of surgeons advocate postoperative roentgen therapy when the axillary nodes are found to contain tumor cells and omit it when the nodes are negative. But it is not always justifiable to say, "I will do thus and so if the axillary nodes are positive or negative." Saphir and Amro-

min,¹⁹ in a careful and extended re-examination of specimens previously diagnosed as "axillary contents negative," have found malignant cells in 30% of the cases. This is important to remember, if we are using such criteria to advocate radiation or hormone ablation or chemotherapy.

I will not go into the extensive arguments concerning the merits of radiation alone or simple mastectomy and radiation as practiced by McWhirter²⁰ in Scotland, Watson²¹ in Canada, and Garland²² in this country. Ackerman²³ has written an excellent review of this work. Even Garland²² admits an increased morbidity after radiation. There is also general agreement that postoperative radiation of the axillary area is a contributory factor in edema of the arm.

The Use of Supraradical Surgical Techniques

Halsted¹ advocated removal of the supraclavicular nodes in 1899 and then abandoned it. Wangensteen²⁴ reported on a greatly extended radical procedure, including the supraclavicular area, the internal mammary chain, and the anterior mediastinum, and found nodes in 60% of the cases which otherwise would not have been suspected. Handley,²⁵ Urban,²⁶ and Yonemoto and Byron²⁶ have pursued the removal of the internal mammary chain of lymph nodes. Similar reports come from Italy, Denmark, Japan, and India.

Most of these authors advocate the extended procedure for inner-quadrant or subareolar tumors. This is based on the fact that parasternal lymph-node involvement was the first sign of recurrence in 10% of those patients with inner-quadrant tumors and in only 2% of those with one of the outer quadrant. Urban²⁶ feels that he has increased the five-year survival rate by an additional 10% by this technique. more significant is his report of 100 cases which were inoperable according to the Haagensen criteria, but in which he achieved a 46% five-year survival rate by the extended operation (removal of the internal mammary chain). This would appear to have much merit.

Adjuvant Chemotherapy

Since the use of adjuvant chemotherapy is the prime tenet of this paper, it would seem worth while to explore the basic reasoning behind it. The use of various alkylating agents began as early as 1943. The original concept was to find a drug which would destroy metastatic growths associated with recurrent inoperable lesions. Widespread evidence has been gathered showing the frequent but often very temporary benefits of such agents as nitrogen mustard and later triethylenethiophosphoramide (Thio-Tepa) and many others.

Bell²⁸ has shown that agents such as Thio-Tepa must be carried by the blood stream and are more effective when the tumors are small and widespread rather than large and possibly necrotic. There is good evidence of tumor regression for nine months or longer in 31% of all treated patients who have had recurrences. The drug reacts directly with desoxribonucleic acid in the nucleus of the cell.

Experimentally, Msarek and Cole²⁹ have repeatedly injected emulsions of cancer cells into the portal or peripheral veins of rats and other animals, with "takes" varying from 91% to 75%. When HN2 is introduced concomitantly, the takes are reduced by 73% in the portal and 40% in the peripheral injections. Similarly, McDonald and Cole¹³ have shown that when cancer cells are introduced in wounds created in the abdominal wall, the takes can be reduced by as much as 96% by local washing with various solutions, including alkylating agents, at the same time or within one hour thereafter. When the drugs are introduced through the peripheral veins, the percentage of reduction is decreased but is still very significant. But no patient with metastatic lesions has been cured or even permanently improved by the use of these drugs.

Rationale for combining radical mastectomy and chemotherapy, with or without wound irrigation: Following the reasoning that certain agents will destroy cancer cells, the combined adjuvant chemotherapy study³⁰ was set up with 27 institutions cooperating

initially. Thus far the statistics obtained with the use of Thio-Tepa show a striking reduction (50%) in recurrences of cancer in premenopausal patients having positive nodes. It seems logical to me that all the reasons given for the possible benefits to be obtained from radiation and castration respectively apply with equal if not greater validity to the chemotherapeutic approach.

I believe also that the adjuvant use of chemotherapy has long passed the stage where its possible benefits should be withheld from the average patient. The problems of toxicity, reduction of the leukocyte count, depression of bone marrow, decreased immunologic response (Bell²⁷), and the increased possibility of infection are well known. Anyone practicing in a hospital with an adequate laboratory can look for and avoid these pitfalls.

Method

In our experience we give 0.8 mg per kilogram of body weight in four equal doses over a period of four days. The first dose is given as soon as the diagnosis of malignancy is confirmed by biopsy. Habif's³¹ use of a low-power magnifying lens to study the gross cut specimens seems promising, and we intend to use it in the future. According to him, stellate or irregularly outlined primary tumors seem to be associated with a greater degree of malignancy and lymph-node involvement. The leukocyte count is noted daily; the prothrombin time and hematocrit level are determined on the afternoon of surgery and again on the third and fifth postoperative days. This may be a little more often than necessary, but it gives a better opportunity to detect any untoward reactions. There has been no evidence of morbidity. Since this line of therapy is relatively so innocuous, it seems unjustifiable to wait and see what the lymph nodes I have already indicated that the results of routine histologic search are not always completely accurate.

Wound healing is not affected in any way. When in addition to the medication previously outlined the wound is irrigated with an anticancer drug, which I do regularly now, certain changes do take place.

The wound may appear brawny and may be described as temporarily "unhappy," but no delay in healing and no difference in the appearance of the skin or chest can be detected after six to eight weeks.

Various solutions have been used for irrigation. At present I use nitrogen mustard in a 0.1 mg% solution prepared at the table immediately prior to use. The edges of the wound are grasped with towel clips, lifted up to form a basin, and from 500 to 1,000 cc of the solution is poured in, allowing it to remain in contact with the wound for four minutes. Although Cole¹³ has continued to experiment with other solutions, the reduction of takes associated with this solution remains greater than with any other to date.

Results in Fifty Cases

I began to use adjuvant chemotherapy in 1960 and thus far have treated 50 cases. In this group there has been no operative mortality nor increases in morbidity. One patient complained of a tight, drawing sensation in the skin flap, and the wound appeared definitely brawny and tight for six weeks. In this case a 0.2 mg % solution of HN2 was substituted for the usual 0.1% solution.

From 1958 through 1962 all surgical patients who did not receive chemotherapy averaged 11 days postoperative hospital stay. In the same period the average hospital stay for all patients receiving chemotherapy was $8\frac{1}{2}$ days.

At present all 50 patients are living, with evidence of recurrence in only 2. Thirteen of the 50 had axillary nodes positive for tumor cells. There are two known recurrences. One patient had positive nodes at the time of operation, and the other was reported negative.

Case Reports

Case 2

A white married woman, aged 51 and postmenopausal, underwent a radical mastectomy for cancer of the left breast on May 11, 1962. She received 15 mg of Thio-Tepa intravenously for four days and the wound was irrigated with 500 ml of a solution of HN2 (0.1 mg/100 ml). The lesion measured 3 x 4 x 4 cm, was located in the nipple line just

beneath the clavicle, and on histologic examination was found to be an infiltrating duct carcinoma with positive axillary nodes.

On April 11, 1964 (23 months later) a routine follow-up roentgenogram disclosed three oval densities in the left upper lobe measuring from 8 to 10 mm in diameter. Retrospective studies showed that the larger lesion had been present on November 8, 1963, then measuring 0.5 mm in diameter and Estrogenic therapy was appearing less dense. started and continues to this date. A total hysterectomy and bilateral salpingo-oophorectomy was performed on December 3, 1964, because of annoying Two of the vaginal bleeding, estrogen-induced. pulmonary lesions have disappeared, and the third can be outlined at about one-fourth the original size.

Case 3

The patient was a 59-year-old widow with a 3 cm mass in the upper outer quadrant of the left breast and bleeding from the nipple fcr three to four months. A radical mastectomy with adjuvant chemotherapy was performed on August 18, 1964. Histologic studies showed an intraductal papilloma associated with an infiltrating duct carcinoma. The axillary nodes were considered negative for cancer calls

The patient did well postoperatively, but on July 12, 1965, was found to have an irregular rubbery mass measuring 2½ cm in diameter beneath the upper third of the mastectomy scar, not attached to the skin. The axilla was negative to palpation and the roentgenographic survey was negative. At operation on July 14, 1965, this mass was found to be a recurrent malignant lesion involving the fascial covering of the serratus anterior. Wide excision of the chest wall area was performed. It is probable that a clump of tumor cells remained in the area at the time of the original operation.

Conclusion

Obviously this is too small a series of cases from which to draw extensive conclusions. I think it does demonstrate, however, that surgery with adjuvant chemotherapy provides a safe approach to treatment of cancer of the breast, and that the morbidity is not increased thereby. It is a logical method of combining safe, known anti-cancer agents with time-proven therapy for this condition. Further follow-up studies will be carried out.

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Indeed, no part of medicine is of more general importance than that which relates to the nursing and management of children. Yet few parents pay a proper attention to it. They leave the sole care of their tender offspring, at the very time when care and attention are most necessary, to hirelings, who are either too careless to do their duty, or too ignorant to know it. More lives are lost by the carelessness and inattention of the parents than are saved by the faculty.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 20.

Pulmonary Embolism

Review of Fifty Autopsy Cases in Which Pulmonary Embolism Was the Cause or a Major Contributing Cause of Death

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The importance of pulmonary embolism and associated venous thrombosis is emphasized by the estimate that this vascular accident may be the sole cause of about 50,000 deaths annually in the United States.^{1,2} It also probably contributes to at least four times that many fatalities. It is all the more unfortunate that the underlying cause of venous thrombosis and embolism is poorly understood, that clinical recognition of these disorders is difficult, and that the methods of treatment are still controversial. The effectiveness of some forms of treatment³ is clearly established, and a growing experience indicates that appropriate therapy may be life-saving in many cases. Needless to say, the cornerstone of rational management is early diagnosis.

This is a report based on autopsy reports and review of the clinical records of 50 cases, 42 from Presbyterian Hospital in Charlotte and 8 from Charlotte Memorial Hospital. In all cases, pulmonary embolism was the cause, or a major contributing cause, of death.

Initial Diagnosis and Underlying Disease

In only 9 cases (16%), was pulmonary embolism or infarction the working clinical diagnosis. In 9 cases (18%), pulmonary embolism was anticipated or suspected, according to the clinical records. In the remaining 33 (66%), it was felt that pulmonary embolism was not suspected or anticipated. In other autopsy series, only 5%-10% of the cases were recognized clinically.

The underlying diseases, in order of frequency, included 23 cases of heart disease (Table 1). Fifteen of these patients had coronary disease, 5 had congestive heart failure, and 3 had hypertension. Cancer was present in 13 cases; peripheral arterial disease (occlusion or thrombosis of the

aorta or major arterial tree) in 5 cases, and acute trauma in 4 cases, including fractures of the hip, femur, and spinal column. Four cases were postoperative, including prostatectomy, hernia repair, varicose vein repair

Table 1 Common Underlying Diseases

common chachying Discuses	
Heart disease	(23)
Coronary disease	(15)
Congestive failure	(5)
Hypertension	(3)
Malignancy	(13)
Peripheral arterial disease	
Acute trauma	
Postoperative state	
Diabetes	
Thrombophlebitis	
Cerebrovascular disease	

and cholecystectomy. Two patients had diabetes and two had thrombophlebitis. The remaining underlying diseases included cerebral thrombosis, cerebral aneurysm, and encephalitis.

The source of the emboli (Table 2) was the femoral or peripheral leg veins in 18 cases; iliac or pelvic veins, 12 cases; right atrium, 5 cases; right ventricle, 1 case; generalized venous thrombosis, 1 case; and a cut-down catheter in 1 case. The source of the emboli was unknown in 12 (24%) of the cases. These findings correspond with the general impression⁵ and reports from the

Table 2 Source of Emboli

Source of Empon	
Lower extremities	> 60%
Iliac or pelvic veins	
Right atrium	> 12%
Right ventricle	
Cutdown catheter	2%
Unknown	24%

literature that the majority of pulmonary emboli arise from the veins of either the pelvis or the legs.

As might be expected, anticoagulants were used in only 11 (22%) of the cases.

Roentgen Findings

Chest x-rays were obtained in 35 of the 50 cases, and multiple x-rays were made in 18. The x-ray diagnosis of pulmonary infarction was made in only one case. In two cases, pulmonary infarction or pneumonia was given as a differential diagnosis. The most frequent x-ray diagnoses (Table 3)

Table 3
Roentgenographic Diagnoses

	No. Cases
Heart failure	8
Pleural effusion	8
Pneumonia	7
Pleural reaction	7
Tumor	2

*X-rays disclosed abnormalities in 30 cases

included heart failure or pulmonary congestion, 8 cases; pleural effusion, 8 cases; pneumonia, 7 cases; pleural reaction, 2 cases; atelectasis, 2 cases; and 1 each of neoplasm or tumor, increased radiolucency, tumor, or infiltrate. Six of the x-rays were reported as normal.

The numerous x-ray patterns observed in patients with pulmonary embolism or infarction are influenced by the size, number, and distribution of the emboli, the pre-existing state of the heart and lungs, and the frequency with which chest x-rays are obtained. Before frank infarction develops, films usually show no readily demonstrated abnormalities. At this stage, x-ray findings are usually inconclusive, but pulmonary arteriography or scanning may demonstrate the size and distribution of the emboli.

After infarction occurs, x-ray findings as shown by our series are extremely varied. The lung densities range from bare visibility to a completely consolidated lobe. Patterns of density are so diversified that no shape should exclude the possibility of pulmonary infarction. Contrary to popular belief, the typical x-ray representation of pulmonary infarction was not a wedge-shaped density in our series, where this abnormality was observed in only one case. The lower lobes of the lung are involved most frequently, the right more than the left. In about 15% of the cases pulmonary

infarction may be confined to one or both of the upper lobes.

As seen in our series, pulmonary infarction simulates many diseases. It is often mistaken for pneumonia and occasionally for cancer. When cavitation occurs it is confused with pulmonary abscess. When recurrent non-fatal pulmonary emboli occur, chronic cor pulmonale may develop, and the chest x-ray will then show normal or decreased pulmonary vasculature, and right ventricular and right atrial enlargement. This finding, together with signs of right heart failure, should lead one to suspect chronic pulmonary emboli as the cause.

Cardiac Findings

Electrocardiograms were obtained in 37 of the cases, 23 (62%) of which indicated tachycardia or significant arrhythmias. The most frequent arrhythmias were atrial fibrillation and ventricular ectopic beats. Tachycardias were usually 120 beats per minute. The typical right strain or cor pulmonale pattern was present in only one case, although many of the ECGs were not done until several hours or days after the pulmonary emboli had occurred.

Of the six patients with pulmonary emboli coming from the right side of the heart, three had atrial fibrillation. Two had no arrhythmias recorded on ECG. One patient had no ECGs done and no mention of arrhythmia.

As can be seen in most patients with pulmonary embolism, the ECG shows no clear-cut diagnostic abnormality. Pre-existing cardiac or pulmonary disease may interfere to varying extent with the development of ECG changes suggesting pulmonary emboli. Tachycardia and arrhythmia seem to be the most frequently reported abnormalities.

Laboratory Findings

Laboratory studies were reviewed, but as far as could be determined none of the other tests were of any help in the differential diagnosis. In other large series where serum enzyme studies were done, it was found that the lactic dehydrogenase (LDH) is frequently increased, but that the SGOT usually remains within normal limits.⁴

Discussion

From these findings it is concluded that pulmonary emboli and infarcts are (1) often unrecognized, (2) rarely diagnosed by the use of x-ray or electrocardiograms alone, and (3) usually inadequately treated.

Diagnosis

A high index of suspicion must be present in order to make the diagnosis, especially in patients with cardiovascular disease, peripheral arterial or venous disease, cancer, trauma, and postoperative conditions.

Pneumonia is the disease with which pulmonary infarction is confused most often, because both disorders may be characterized by dyspnea, cough, pleuritic pain, fever, and x-ray abnormalities. Chest pain, when of severe and sudden onset, is more suggestive of pulmonary infarction than of pneumonia. Pneumonia patients frequently relate a story of gradually increasing malaise, followed by chills and productive cough. By contrast, patients with pulmonary infarction often become ill with dramatic suddenness, experiencing chills only if the infarction becomes infected.

On physical examination patients with pulmonary infarction are typically quite dyspneic and often apprehensive, usually out of proportion to the associated physical Cases of pneumonia and x-ray findings. which are "unresponsive to therapy" often turn out to be pulmonary infarctions. Examination of the sputum often aids in the differential diagnosis. In pneumonia, the sputum is often purulent and contains pathologic bacteria. In pulmonary infarction, the sputum, when present, is sometimes bloody and contains few bacteria or inflammatory cells.

Repeated embolic phenomena usually precede fatal embolization, and continued embolization of the pulmonary bed by small emboli may lead to fatal obstruction. Early diagnosis and prompt therapy could reduce this mortality: when patients are adequately treated with anticoagulants, mortality from recurrent emboli is reduced by 50%.

The most significant clinical signs include tachycardiac, dyspnea, chest pain, unexplained fever, rales, cough, and vascular collapse. X-ray and ECG changes are frequent, but are not diagnostic. Dyspnea and chest pain in patients with cardiovascular disease are often wrongly attributed to underlying congestive heart failure or lung disease. Cough and fever are often thought to be due to pneumonia rather than to pulmonary infarction. The diagnosis of pulmonary infarction in most cases, then, can only be presumptive.

Treatment

The ideal treatment of pulmonary embolism is prevention of the initial thrombus formation. In order to accomplish this purpose, early ambulation is recommended for postoperative and postpartum patients. In the patient who cannot get out of bed, some sort of leg exercise is of value if it does not interfere with his underlying problems. Prophylactic anticoagulant therapy is presently being used in most cases of myocardial infarction with very little associated morbidity. Anticoagulants are also the preferred means of preventing venous thrombosis in injured or postoperative patients and those with congestive heart failure. These drugs are especially recommended for patients over 40 years of age who are likely to be confined to bed for more than four or five days. Elastic stockings and wraps are so often ill-fitting or misused that their use is not routinely recommended, especially if the patient is confined to bed.

Once there is reasonable suspicion that pulmonary embolism has occurred and a working clinical diagnosis is made, therapy should be begun immediately. The initial therapy of choice is heparin, given either intravenously or subcutaneously. The intramuscular route is less reliable than the subcutaneous, and may produce painful hematomas deep in the muscles. Depoheparin is absorbed erratically and should not be used.

Aqueous heparin in concentrations of 10,000 or 20,000 units per ml is the most useful form of the drug. The effect of 10,000 units per milliliter given subcutaneously lasts from six to eight hours, and that of 20,000 units per milliliter for 12 to 14 hours. An initial dose of 20,000 units is usually

given, and then the dosage is adjusted in accordance with the Lee-White clotting time. Once the dosage is established, the clotting time may be determined only every three or four days. The medication can then be switched to the oral coagulants, which should be continued for at least three months after the venous thrombosis or underlying disease is under control.

None of the patients in our series were treated surgically. In cases of recurrent pulmonary emboli that cannot be controlled by medical means, or where the cardiovascular status is poor, surgical measures to prevent emboli are indicated. Unilateral femoral ligation is usually not indicated and is ineffectual, as the source of the pulmonary emboli may be in the pelvic veins or in the opposite leg. The procedure of choice is either plication or ligation of the inferior vena cava, plication causing the least morbidity.

Emergency surgery for massive acute pulmonary embolism is now a reality. Pulmonary embolectomy utilizing temporary cardiopulmonary bypass can be carried out, removing the blood clots by manual compression of the lungs. Prompt, accurate diagnosis is a prerequisite to the use of this procedure. The studies which give the most reliable results are pulmonary angiography, done by injecting dye through a catheter into the pulmonary artery or right ventricle, and pulmonary scan, using macroprecipitated serum albumin ¹³¹I. This product is now available for clinical use and will soon be available for local use.

Summary

Fifty deaths due to pulmonary embolism in a community hospital setting are reviewed.

In only 16% of the cases was pulmonary embolism the working diagnosis; in another 18% embolism was suspected, so that in 66% the clinical diagnosis was not made. The most frequent underlying diseases were heart disease, cancer, trauma and postoperative states. The legs, pelvis, and heart were the source of most of the emboli. The most frequently confused disease, both by x-ray and clinical diagnosis, was pneumonia. X-ray findings are rarely typical. Electrocardiographic and laboratory findings in this series were of little help in diagnosis.

Clues to earlier diagnosis are presented, Prevention and treatment are discussed, early and prophylactic use of heparin followed by oral anticoagulation being the cornerstone of therapy. The surgical treatment of choice is interruption or plication of the inferior vena cava. With increasing awareness of the problem, measures to prevent vena stasis, early diagnosis and prompt adequate therapy, deaths from pulmonary emboli can probably be reduced by as much as 50%.

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Cases will sometimes occur, where a prudent physician may find it expedient to disguise a medicine. The whims and humours of men must be regarded by those who mean to do them a service; but this can never affect the general argument in favour of candour and openness.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 18.

Aneurysm of the Left Ventricle with Peripheral Embolization

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Coronary heart disease is on the increase; so are its complications. A most unwanted sequela of myocardial infarction is aneurysm formation of the ventricular wall, which occurs in 10-38 per cent of all infarcts. Nine out of ten of these patients die within five years of the initial infarction. This record compares most unfavorably to that of the group with coronary occlusive disease without aneurysm formation.

These ventricular aneurysms endanger the life and lessen the chances of recovery in the following manner:

- 1. The wall of the aneurysm is usually paper-thin, non-resistant scar-tissue. Approximately 11% of all patients having myocardial infarctions die because of rupture of the aneurysm, exsanguination, or cardiac tamponade.8
- 2. Mural thrombus formation within the aneurysmal sac is the rule rather than the exception. These thrombi frequently dislodge,⁴ causing death or permanent disability.
- 3. The most frequent cause of death has been congestive heart failure, The aneurysm dilates paradoxically with each systole, substantially depleting the effective stroke volume. The compensatory effort of the heart often leads to increase in the rate, dilatation, and finally congestive failure.

Better understanding of the natural history of ventricular aneurysms and the recent development of a surgical approach to treatment have directed more attention to this disease than formerly. Because the experience with the operative approach is still limited, we thought it worth while to present our results of the surgical treatment of a patient with post-infarction left ventricular aneurysm and peripheral embolization

using the "open" technique and extracorporeal circulation.

Case Report

Our patient was a 34-year-old business man, previously a Big League professional baseball player, who had been in good health until June 15, 1964, when he experienced severe pain in the chest and upper part of the abdomen, radiating to the left arm. The diagnosis of a myocardial infarction was made, and the patient was hospitalized for five weeks in his home town. He did well on anticoagulant therapy and was just beginning to be ambulatory.

On July 23, 1964, just after supper, his right leg became numb, cold, and pale. He was then transferred to the Charlotte Memorial Hospital for an emergency embolectomy.

At the time of his admission the patient appeared to be a well developed, slightly overweight young man, who complained of severe pain in his right foot. On physical examination the heart appeared moderately enlarged and the heart sounds were distant. The lungs were clear on auscultation. The pulse was 100 per minute, regular and equal; the blood pressure 120/70 in the left arm. The right foot was pale, cyanotic, cold, and extremely tender. Pulsation of the right common femoral artery was vigorous, but no arterial pulsation could be felt below this level.

A femoral arteriogram (Fig. 1) showed a large embolus lodged in the terminal part of the right common femoral artery, partially occluding both the external and deep branches. The artery was explored, with the patient under local anesthesia, and the embolus was removed. The restoration of the blood flow was rapidly followed by the disappearance of signs of ischemia.

Fluoroscopic examination and x-ray films

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Fig. 1. Femoral arteriogram. The filling defect in the common femoral artery clearly outlines the contour of the embolus.

of the chest done the following day revealed the heart to be moderately enlarged, with a localized bulge on the anterolateral portion of the left ventricle. This was interpreted as representing a postinfarction aneurysm. The diagnosis was further supported by cinefluorography, which showed definite paradoxical motion in this area. The ST segment was elevated on the electrocardiogram in the first and second standard leads, as well as in V 3-6. The QRS complex was positive in the lead.

The serum cholesterol level was 344 mg/100 ml, and the serum glutamic acid transaminase 28. The white cell count was 9,750/cu mm. The other laboratory finds were noncontributory.

Because of the danger of further embolization and the possibility of a rupture and exsanguination, it was decided to resect the ventricular aneurysm.

The operation was done on August 12, 1964, with the use of endotracheal oxygen-fluothane anesthesia, cardiopulmonary bypass, and total body hypothermia. The heart

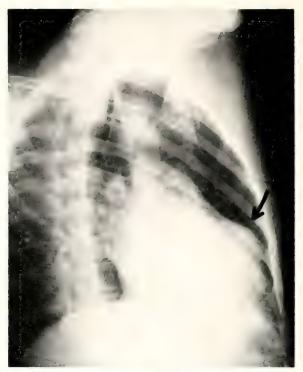


Fig. 2. Roentgenogram of the chest in the right anterior oblique position shows the apical bulge of the left ventricular aneurysm.



Fig. 3. Operative situs. The heart is explored, cannulated, and chilled by direct application of ice. The large aneurysm of the left ventricle is clearly visible.

was exposed through a median sternotomy. The aneurysm was located close to the apex, on the anterior surface of the left ventricle. Its wall was paper-thin and filled with loosely attached, friable clots. Using temporary cardiopulmonary bypass and moderate (28 degrees) hypothermia, the aneu-

rysm was opened, clots were evacuated, and the sac was resected. The defect on the ventricular wall was closed with 00 silk and was reinforced with interrupted Mersilene sutures tied over strips of Teflon felt. The coronary blood flow was not interrupted during the procedure, and the heart continued to beat regularly and forcefully during the entire period.

The patient tolerated the procedure well, and the circulation was easily maintained in a well compensated state during the post-operative period. The only complication encountered was an episode of thrombophlebitis of the left calf, which responded well to conservative treatment. The patient was discharged 28 days following his heart operation and has been followed since then. He continued to progress satisfactorily and now he is back in part-time work.

Discussion

The first description of the postinfarction ventricular aneurysm was made by Hunter,¹⁰ and it was based on autopsy findings. Nearly three hundred years passed before Sternberg¹¹ made the first diagnosis during life.

Diagnosis

The diagnosis of ventricular aneurysm is based primarily on the history of myocardial infarction and on electrocardiographic and x-ray findings.

The electrocardiographic features of this disease have been studied by several authors. The most characteristic finding appeared to be the persistent upward QRS complex in the AVR lead. This was also substantiated by Lillehei, how found this sign in four out of five of his patients. Laake has found the persistence of an acute myocardial infarct pattern for several months to be highly suggestive of aneurysm formation. Chapman observed persistence of an "acute infarction pattern," namely deep Q waves and changes in the ST-segment in all of the 14 patients studied.

The most valuable aid in the diagnosis of ventricular aneurysm is undoubtedly the radiologic examination. The conventional posteroanterior, right, and left anterior

oblique views may reveal localized enlargement of the left ventricle with deformity of its contour. The localized, paradoxically pulsating bulge of the left ventricle may be best seen on fluoroscopy or cinefluorography. The contrapulsation may be absent if the sac is calficied, or if its cavity is filled with thrombi. Special studies, such an angiocardiography and heart catheterization, are seldom helpful.

Surgical techniques

The first operation for ventricular aneurysm was done by Sauerbruch¹³ in 1931, who inadvertently incised an aneurysm of the right ventricle. He was able to control the bleeding as well as to resect the aneurysm. Lillehei,⁶ in 1962, collected 53 surgical patients in literature and added five of his own cases. These operations could be divided into three different categories.

The first planned operation for postinfarction aneurysm was done by Beck⁴ in 1944. He used free graft of fascia lata to reinforce the wall and prevent further expansion. Plication sutures were also placed into the center of the sac to reduce its size. Methods similar to Beck's were practiced by others who used skin,¹⁵ intercostal muscle,¹⁶ pectoralis muscle and diaphram,⁷ as pedicled or free transplants. These methods proved largely inadequate and were abandoned.

In 1954 Likoff and Bailey¹⁸ successfully resected an aneurysm and performed a ventricoplasty. The operation employed the "closed" technique, without interrupting the blood flow. A limited number of patients operated on with this technique were reported by DeCamp,⁹ Bailey and others,¹⁹ Niedner,¹⁵ and recently by Petrovszkij.¹⁷

At present the generally accepted procedure is the "direct vision" excision of the ventricular aneurysm with the aid of temporary cardiopulmonary bypass. This method is the safest with regard to evacuation of blood clots and prevention of intraoperative embolization, and permits accurate excision of the sac and preservation of functional myocardium. The first such procedure was done by Cooley¹² in 1959; his paper was soon

followed by the case reports of Kay,²⁰ and Lillehei.⁶ The operative mortality reported by these authors was relatively low and the clinical improvement remarkable. There were no further episodes of embolization, fatigue, and left ventricular failure; the angina disappeared and a general feeling of well-being was noticeable in most of the patients.¹³ On the basis of these reports, as well as on our own limited experience, it appears that direct vision heart surgery is a feasible and rational approach to the treatment of postinfarction ventricular aneurysm if the sac is of sufficient size to cause clinical symptoms.

Summary

A case of postinfarction embolization and aneurysm formation of the left ventricular wall in a 34-year-old man is presented. The patient underwent a successful embolectomy and resection of the aneurysm. The merits of the surgical treatment of ventricular aneurysms are discussed in detail.

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Very few of the valuable discoveries in medicine have been made by physicians. They have, in general, either been the effect of chance or necessity, and have been usually opposed by the faculty, until everyone else was convinced of their importance.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 17.

Mobile Psychiatric Consultation for Local Physicians

A Preliminary Report

J. L. CATHELL, M.D.*

MORGANTON

and

N. E. STRATUS, M.D.†

RALEIGH

The family physician is a key member of the treatment team handling the patient suffering from emotional illness. If he is not involved, continuity of treatment is diffi-He is often the first professionally trained person consulted when such an illness becomes a problem to the patient, or the patient becomes a problem to his family or community. Often the physician is aware of an emotional illness before the patient or family is. His presence during births, deaths, and other crises makes for a close personal relationship. He is familiar with the patient's history, and indeed that of his family, sometimes extending over several generations. In many communities the physician is the best educated and one of the most highly respected citizens. For these reasons he is in a uniquely advantageous position to recognize, treat, and prevent mental illness.1

In the past decade many programs have been conducted throughout the country to inform and aid the physician in the treatment of mental illness. The majority have been sponsored by universities, departments of mental health, clinics, or medical societies; and usually they have been of the seminar or lecture type. Some have included supervised case work of various kinds, but in most instances these have been limited to urban areas or educational centers.2 Limited psychiatric consultation has been offered in Vermont³ and Kentucky.^{4,5} A clinic in Minnesota employs consultation for the family physician instead of staff-conducted therapy. 6 A new project in Nebraska offers consultation or supervision in treatment. All the studies that have been done on these

projects were conducted on a part-time, somewhat limited basis (many by telephone); however, it is generally concluded that consultation is a practical and economical method, in terms of both manpower and money, of providing psychiatric treatment. In general it is felt that this method should be carried further to evolve or refine techniques and procedures. Although physicians have shown varying degrees of interest, the reception has been generally favorable.

Many physicians attend psychiatric seminars and training programs, but the majority are reluctant to use the knowledge they acquire in actual treatment situations. Our program is designed to aid the physician in his office, the local hospital, and in the home with on the spot help in diagnosing, evaluating, and planning treatment.

Several studies have shown that the average family physician uses a different approach in treating psychiatric illness from that of the psychiatrist.8 His techniques are more directive than those traditionally employed in psychiatric therapy; however, having treated both psychotic and neurotic patients for many years by this method, he is quite comfortable and often successful with it.9 It is generally agreed that the good family physician knows how to "handle" people. 10,11 In our project, we do not attempt to alter his methods, but reinforce them by making available fundamental psychiatric principles and specialized diagnostic and therapeutic procedures and methods, including chemotherapy. 12,13 We think that his methods are best for him, in his particular orientation and situation.

The specialized knowledge of the consultant enables the physician to evaluate cases earlier and more accurately.¹⁴ He learns how

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to distinguish between cases which require hospital care and cases that may be handled in his office with the help of a consultant; and, probably more important, he is enabled to plan a program of treatment and make a realistic prognosis. By setting realistic goals, he may avoid much frustration for both himself and his patient. With proper evaluation of prognosis, he can assume a more positive and confident attitude toward chronic psychiatric illness, just as in the case of some physical diseases, and this confidence can be beneficial in both types of cases.

Organization and Procedures

Dr. Eugene Hargrove, Commissioner of Mental Health for North Carolina, and Dr. John Kernodle, president of the North Carolina Medical Society in 1963, first proposed a program to bring a traveling psychiatrist, on a regular basis, to local physicians for consultation and help in dealing with the emotional problems of their patients. Direct patient service by the consultant was to be minimal. One of the points stressed by Dr. Hargrove and Dr. Kernodle was that contact be made through county medical societies. Then, if the group approved, the psychiatric consultant would work with interested physicians.

In January, 1964, Dr. Hargrove met with representatives of some of the western North Carolina medical societies. At this meeting the physicians showed much interest in the program. They discussed possible methods and procedures of carrying out such a program. During April, May, and June the consultant met with individual county societies and scheduled dates for later meetings with the interested physicians.

One of the problems was finding a satisfactory meeting time for the consultations, with so many busy physicians holding different ideas. Some physicians preferred seeing the consultant in their offices during regular hours; others preferred the local hospital, either during the day or evening; others wanted to meet at meal-time or in the evenings at their homes; still others

preferred meeting on their "day off." During the year some physicians settled on combinations of the above.

At the original meetings with the physicians, it was stressed that we were undertaking a project that was without set procedures and would be subject to change at the suggestion of the physician or the consultant. Most changes were made upon suggestion of the physicians. The consultant's main point of difference concerned requests to see the patients with the physician. The consultant had no objection to an initial interview, but he explained the risk of gradually coming to replace the local physician if the sessions continued.

During the year most of the procedural problems were worked out, and a typical visit now consists of a few minutes of general discussion about problems of evaluation or treatment or both. A varied amount of time is spent on from six to eight previously discussed cases and the progress made, but most of the interview is devoted to from one to three new patients—the diagnosis, plan of treatment, method, and prognosis. In rare instances, the consultant holds a brief interview with the patient.

The majority of physicians express enthusiasm over this project and seem to get adequate support from it. Regular visits are scheduled at monthly intervals, supplemented by offers "to stop by at any time" at the physician's request, telephone consultations (each physician has the consultant's itinerary), and outpatient visits at the hospital when necessary.

Assessment and Prospects

We hope during the coming year to expand the program and refine, and possibly define, exact techniques. Probably within another year, study of statistical reports of admissions would be significant in evaluating results. To realize the full value of the program, we would have to include the potential for training and teaching. Not only does the program provide an opportunity for the physician to learn, through aid with case work, but trainees from state hospital staffs, both graduate and undergraduate, can be given instruction and field work in

community psychiatry. Hopefully, this type of service will become a vital part of any local mental health program.

Actual progress is difficult to assess at this stage; however, most of the physicians have been enthusiastic with the program. We think it is significant that during the last six months all of the participating physicians have been more active in treating emotional problems. In the beginning it was hoped to involve one or two interested physicians in Surprisingly, in the four each county. counties that have been covered during the past year, 85 per cent of all physicians in the area, regardless of specialty or orientation, have taken an active part in the work and have expressed satisfaction with it. The chief complaint we have encountered was, "You don't come often enough." One physician stated, "Now I feel that I have failed when I have to admit a patient to the state hospital."

Four-fifths of our state's population lies in rural areas or towns of less than 5,000,¹⁸ and in spite of the rapid expansion of our community mental health program, only a small per cent of these people can obtain psychiatric help without extensive travel. Many of our existing clinics have vacancies for trained professional personnel. Because of this shortage, we must involve local professional people in the treatment of mental illness.

Our project is designed to help the family physician treat the patient before or instead of sending him to the hospital; to keep him informed of his patient's progress, if hospitalization is necessary; and to assist him in the treatment of discharged patients.

Probably most important, our aim is the aid the physician in treating the patient who does not have to go to the hospital, but who needs treatment in the community.¹⁹

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... the man who adds one single fact to the stock of medical observations does more real service to the art than he who writes volumes in support of some favourite hypothesis.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 17.

Physiologic Septoplasty and Rhinoplasty

CARL N. PATTERSON, M.D. DURHAM

Deformities of the nose are divided for descriptive purposes into two categories: internal and external. Before the days of antibiotics nasal deviations often were not corrected for fear of infection and for lack of knowledge and experience in handling these problems. Often an external deformity was accentuated or created in an endeavor to correct severe deflections of the caudal end of the septum. If the caudal deflection was left untouched for fear of creating a saddle nose or a retracted columella, the patient still had the problem of nasal obstruction. If, on the other hand, enough of the septum was resected to correct the obstruction, a saddle nose was almost sure to occur. Today these deformities can be handled in such a way that the patient will have a nose that functions well, is stronger than before, and looks better.

Surgical Anatomy

For surgical purposes the nasal septum may be divided into two compartments by an imaginary dorsoventral line beginning at the caudal border of the upper lateral cartilage as it attaches to the septum and extending to the maxillary crest dorsally. The part lying above this plane is called the cephalic compartment, and that below, the caudal. Deviations in the latter compartment are properly handled by the septoplastic techniques.

Several approaches to caudal septal deformities have been described. For the past nine years I have used a technique that has produced satisfactory results in a high percentage of cases.

This technique has several salient features:

1. The first incision is made on the side opposite the principal deflection, cephalic to the caudal margin of the upper lateral cartilage as it attaches to the septum.

2. The second incision is made on the side of the principal deflection along the caudal margin of the septum and carried down to expose the anterior nasal spine (a hemitransfixion or transfixion incision may be made as the case necessitates). The mucoperichondrium and periosteum is elevated completely on this side.

3. The cartilage is transected at the level

3. The cartilage is transected at the level of the original incision, and obstructing bone and cartilage are removed or realigned as necessary.

4. The caudal septal strut, which still has mucosa on one side, is replaced in the anterior nasal spine and maxillary crest by resection, shaving, and cross-hatching.

The tip and lobule of the nose are next evaluated. Many caudal septal deviations are associated with deformities of the medial crura and columella, an often neglected area that is frequently the site of the principal deviation producing nasal obstruction. This portion of the nose deserves special attention. One has only to compare the nose of the normal child with that of the adult and aged person to realize what happens in the deformed tip. The aging process is accompanied by loss of elastic tissue, manifested in the nose by drooping of the tip and retraction of the columella. This deformity without septal deflection causes obstruction to inspired air.

This deformity is frequently associated with deviations of the caudal spetum. If left uncorrected, the nasal obstruction will persist after the septal deviation has been repaired. To correct this condition, a 3 to 4 mm incision is made at the base of the nose on each side of the columella caudal to the feet of the medial crura of the lower lateral cartilages. With small scissors a pocket is created anterior to the medial crura all the way to the tip. The pocket is also extended to the anterior nasal spine. If the base of the columella is wide, interposed soft tissue is removed. Sufficient autogenous septal

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From McPherson Hospital, Durham, North Carolina.

cartilage is placed in front of the medial crura and anterior nasal spine to obtain the desired projection of the columella. The base of the columella is narrowed by through-and-through bunching sutures. The tip of the nose is elevated to the desired projection by removing a portion of the free border of the caudal septum.

In the uncommon case involving severe fragmentation, buckling, and compartmentalization, it becomes necessary to remove the major part of the cartilaginous and bony septum. Secondary deformities will occur as the result of scar contraction and lack of support. A saddle nose, drooped tip, retracted columella, and a dissatisfied patient are almost sure to follow if preventive steps are not taken.

I have been unsuccessful in replacing large pieces of cartilage as suggested by Galloway² and Foman.³ The newer plastics have been useful in this problem. Siliconized Dacron and silicone sheet* have been used as replacement for the septum with good results. These materials have been employed in eight patients over an 11-month period without causing deformity or complication. More experience will be necessary before definite conclusions can be drawn, but at this time these materials seem most satisfactory.

When internal and external nasal deformities co-exist, they are best corrected by combined rhinoplasty and septoplasty. By this method a better functional and cosmetic result can be obtained. In my opinion the otolaryngologist who performs septal surgery should prepare himself to do a cartilaginous rhinoplasty. It has been my experience that patients who have had unsatisfactory results from septal surgery will have deflections of the external cartilaginous nose left uncorrected. Corrections of the deformities relieve the patient's symptoms.

The more severe deflections involving the bony and cartilaginous exterior nose as well as a badly deflected septum sometimes offer a real challenge to the rhinologic sur-





Fig. 1 (Case 1). Note shifting of entire cartilaginous nose to the left, with depression of the right upper lateral cartilage.

(All preoperative views on the left; postoperative, right.)

geon. In the more complicated cases great care must be exercised to insure adequate support for the repositioned structures.

Deformities of the Caudal Septum and Nasal Tip

When significant deformities of the caudal septum and the tip coexist they should be corrected by septal reconstruction and cartilaginous rhinoplasty. This procedure takes little additional time and all deviated structures can be replaced in proper position, giving a stronger, better functioning, and better looking nose. The recognition of the deformities is necessary. The nose should be carefully examined in quiet and forced respiration before the nasal speculum is used, as it may hide the principal cause of the patient's symptoms and nasal obstruction.

Case 1

A 23-year-old white man complained of nasal obstruction persisting since childhood. His external deformity was not particularly noticeable until pubescence. Examination revealed saddling of the right upper lateral cartilage with complete loss of tip support. There was marked deviation of the septal cartilage to the right at the limen nasi. The caudal border projected into the left naris. Correction was obtained by a cartilaginous rhinoplasty and septoplasty. He had an improved functional and cosmetic result.

Case 2

A 40-year-old white man complained of difficulty with breathing through his nose for several years.

^{*}Materials supplied by the Research Department, Dow Corning Corporation, Midland, Michigan.



Fig. 2 (Case 2). Note the enlarged and separated lower lateral cartilage in preoperative view.

Examination showed a deviation of the entire cartilaginous dorsum to the left. The lower lateral cartilages were quite large; the medial crura were separated by soft tissue. The columella was twisted and retracted. The free border of the septum projected into the right naris with marked deflection into the left, obstructing 80% of the breathing space.

The deformities were corrected by combined cartilaginous rhinoplasty and septoplasty. An improved cosmetic and functional result was obtained.

Deformities of the Bony and Cartilaginous External Nose and Nasal Septum

Group I. Deviations in which the nasal septum cannot be reconstructed without realignment of the external nose.

In this group the principal purpose is to restore nasal function. These patients readily accept an improved cosmetic result, but this is not the reason the patient comes to the physician.

Case 3

A 43-year-old white man sustained a severe injury to his nose at the age of 13. A septal procedure was subsequently done to correct the internal nasal deviation; however, the symptoms were not improved and became progressively worse. Examination disclosed a severe nasal deformity with displacement of the cartilaginous and bony part of the nose to the right. There was a pendulous tip with large lateral crura of the lower lateral cartilages and marked retraction of the columella, producing a septolabial angle of about 30 degrees. Intranasal examination showed a large septal perforation beginning at the membranous septum and extending back almost to the posterior choana. Correction was obtained by removing the bony hump, elevating and rebuilding the lobule and columella, and using an autogenous iliac crest bone



Fig. 3 (Case 3). A. Lateral views (upper) before and after operation. Note septolabial angle of less than 40 degrees. B. Basal views show correction of marked deformity of the upper and lower lateral cartilages with retraction of the columella.

graft on the nasal dorsum. Lateral osteotomies were not done for fear of nasal collapse, since previous removal of the vomer and ethmoid plates had left virtually no support.

Case 4

A 39-year-old white man complained of inability to breathe through either side of his nose for many years. Examination showed that he had a very large nose, with a bony and cartilaginous hump. The entire nose deviated to the left. There was loss of tip support and retraction of the columella. The free border of the septum projected into the left naris, with a marked deflection in the region of the limen nasi on the right. Ninety-five per cent of both sides of the nose was obstructed to respiratory currents. The nose, I believe, could not have been corrected except by an extensive internal and external procedure. A good functional and an acceptable cosmetic result was obtained by a combined septoplasty and rhinoplasty.

Case 5

A 50-year-old white woman sustained an injury to her nose about a year before being seen here.

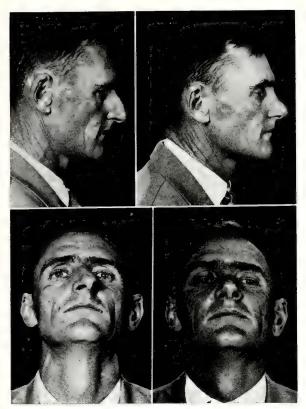


Fig. 4 (Case 4). A. Lateral views (upper). Note large bony and cartilaginous hump with retraction of the columella before operation. B. Preoperative basal view (lower left) shows deviation of the bony and cartilaginous nose to the left.

The initial deformity was minimal, but she had noted progressive nasal obstruction associated with an external nasal deformity. Examination showed a small bony hump immediately above a saddle deformity. The lateral crura of the lower lateral cartilages were large, and the media crura were partially separated. There was loss of tip support with a septolabial angle of about 80 degrees. Internally, the caudal strut projected into the left naris, with concomitant deflection in the limen nasi on the right. A combined rhinoplasty and septoplasty produced an improved physiologic and cosmetic result. Although this patient was 50 years of age, her skin accepted this change of nasal contour and adapted itself satisfactorily.

Group II. Internal and external nasal deviations that are more completely corrected by a combined procedure, although either could be corrected alone.

Cosmetic surgery⁷ used to be frowned upon by laymen and physicians alike. Today, however, this attitude is changing. Personal appearance and self-confidence play a role



Fig. 5 (Case 5). Preoperative view shows a saddle nose with retracted columella.



Fig. 6 (Case 6). Preoperative lateral view (upper left) shows a small bony hump with irregularity of the lower lateral cartilage. B. In the postoperative basal view (lower right) note changed contour of the entire lobule.

in the success of most people. Facial deformities are particularly important, since facial expression is principally conveyed by the eyes, nose, and mouth. We are all familiar with the satisfaction achieved by a successful squint operation, and contrariwise with the psychic trauma done a child by



Fig. 7 (Case 7). A. Lateral views (upper) show correction of the bony and cartilaginous deformity. B. Basal view (lower) shows deformity of the septum and lobule.

neglecting to correct a squint. Yet how many parents and doctors are guilty of allowing a child to develop a personality defect right before their eyes as the result of an external nasal deformity that is not corrected? Such nicknames as "eagle beak," "hook nose," "old nosey," and "bird beak," have impaired the self-assurance of many a child and adult.

The removal of a significant external nasal deformity can do a great deal to improve the self-assurance and confidence of a person and give him a new outlook on life.

Case 6

A 30-year-old white woman complained of nasal obstruction of three years' duration. Examination showed that externally the nose had a wide bony and cartilaginous dorsum. A small hump was present. The lateral crura of the lower lateral cartilages were large; the medial crura were separated and bowed caudally. Internally, the free border of the caudal septum projected into the right naris,



Fig. 8 (Case 8). A. Lateral views show marked change in nasal appearance on removal of a small hump and elevation of the tip. B. Frontal views (lower) show the changed facial appearance achieved by narrowing the entire nose.

with a sharp angle of deflection in the region of the limen nasi on the left. Improved function and appearance were obtained by combined rhinoplasty and septoplasty. Note the change to a softer, more youthful face by the external alteration.

Case 7

A 26-year-old woman presented a history of significant trauma to the nose at about 13 years of age. Difficulty in breathing through the nose had increased during the last few years. Examination showed an external deformity consisting of a small bony hump with slight saddling of the upper lateral cartilages and prominences of the lower lateral cartilages, particularly at the angle of junction. Intranasally, there was subluxation of the caudal portion of the septum, with the free border projecting into the left naris. There was a concomitant deflection on the right side in the region of the limen nasi. A combined rhinoplasty and septoplasty produced an improved functional and cosmetic result.

Case 8

A 22-year-old white woman complained of difficulty in breathing through the nose for the past several years. Examination showed a small bony hump with slight saddling of the lower lateral cartilages below it. The lobule was widened and the columella retracted. The caudal border of the septum projected into the left naris, with loss of tip support. On the right a sharp angle of deflection in the limen nasi obstructed 80% of the breathing space. A combined rhinoplasty and septoplasty produced an improved cosmetic and functional result.

Conclusion

- 1. Nasal deflections of the caudal end of the septum are best corrected by septal reconstructive techniques.
- 2. Deformities involving the cartilaginous dorsum and septum are best corrected by a combined septoplasty and cartilaginous rhinoplasty.
- 3. Significant deformities of the internal and external nasal structures are best corrected by a combined rhinoplasty and septoplasty.

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Report on Trauma

INDICATION, PERFORMANCE, AND MANAGEMENT OF A TRACHEOTOMY IN THE PATIENT WITH AN INJURED CHEST

Tracheotomy is one procedure every practicing physician should be capable of doing. When the necessity arises, it must be done immediately without waiting for the arrival of a specialist.

Patients with chest injuries who are most likely to need tracheotomy are those with:

- 1. Coma and associated head injuries.
- 2. Maxillofacial wounds.
- 3. Flail chest.

Tracheotomy should always be performed whenever excessive secretions or blood cannot be removed from the trachea and bronchi by coughing or intratracheal catheter suction (fig. 3).

Tracheotomy should usually be done when it is first suspected that it is necessary, rather than waiting until it is absolutely essential. Tracheotomies have rarely been done unnecessarily. On the other hand, they have frequently been done too late or not at all. When the procedure is immediately indicated, the circumstance will determine the type needed. If surgical instruments and tracheotomy tubes are available, of course the classical tracheotomy is the procedure of choice (fig. 1). The incision

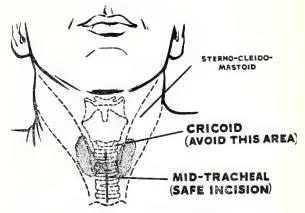


Fig. 1. Site for tracheotomy incision just below the cricoid cartilage to the suprasternal notch (sandbag under the shoulders).

The second in a series of articles submitted by the Committee on Trauma of the North Carolina Chapter of the American College of Surgeons.

Reprinted by request.



Fig. 2. Emergency tracheal stab used only when tracheotomy tubes are not available.

is made over the lower third of the cervical trachea. A sandbag is placed beneath the shoulders. With the index finger and thumb on either side of the trachea, the incision is carried through the skin and the platysma. Then the strap muscles over the trachea are separated. The trachea is exposed, and at least two tracheal rings are incised longitudinally. Either side of the incised trachea is grasped with an Allis clamp, and a small window is made in the trachea for placement of the tube.

When only a knife, be it just a pocket knife, is available, the cricoid membrane stab (fig. 2) is justified, but it should be used only when the classical tracheotomy cannot be done. Extending the neck, one can feel the large thyroid cartilage, and just beneath it, with the index finger, a V can be felt in the cricothyroid membrane. With the transverse incision through this superficial and soft area, one can rapidly enter the trachea. Then with the handle of a penknife, the incision can be held open until something more adaptable is available.

The care of the tracheotomy tube is simple. A clean airway is maintained by insertion of a small catheter just far enough to stimulate cough. Gentle suction aids in removal of secretions.

The hazard of prolonged suction is real

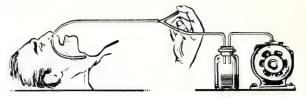


Figure 3.

and often results in anoxia and even cardiac arrest. A Y-tube inserted between the suction machine and the catheter will obviate this complication. The finger is applied to the end of a Y-tube, and aspiration is maintained only as long as the physician can hold his own breath (fig. 3).

At the appropriate time for removal of the tracheotomy tube, no dressing is applied. The edges of the skin are approximated with adhesive tape, and healing is completed within a few days.

About 25,000 babies with heart malformation are born each year in this country, the North Carolina Heart Association reports. About half of these infants die during their first year of life.

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FEBRUARY, 1966

IMPROVING SURGERY FOR BREAST CANCER

Since the turn of the century radical mastectomy has developed as the indicated primary treatment for carcinoma of the breast. This is based on the theory that more patients can be cured if the regional lymph drainage is removed with the cancer. Actually, there are no controlled scientific studies to support this theory. That opportunity was lost half a century ago when the operation was developed and popularized.

During the past 15 or 20 years there have been spotty attempts to improve on radical mastectomy. Simple mastectomy combined with radiation has had considerable use. Simple mastectomy alone has been advocated, on the theory that regional lymph nodes containing tumor could destroy the tumor they contain and that radiation would interfere with this immunologic response. Also employed are extremely radical procedures to remove more surrounding tissue than is removed with the radical mastectomy, and varied forms of chemotherapy.

The most logical primary chemotherapeutic adjunct to treatment of carcinoma of the breast is the intravenous administration of antitumor drugs during surgery to help prevent metastasis which might occur during the operation, as described by Schiebel in this issue of the JOURNAL. The effectiveness of this treatment is based on a triple premise — that cells are shed from the tumor during the operation, that these would cause metastasis if not influenced, and that chemotherapy will render the cells incapable of originating metastases. The approach in certainly worth consideration as a scientific evaluation; one current incorporates the surgical services of several institutions as a cooperative effort. Until there is definite evidence that concommitant intravenous chemotherapy offers definite advantages, it should be considered an experiment, to be used by people such as Dr. Schiebel who are accustomed to the use and investigation of anticancer chemotherapeutic agents.

Washing the surgical wound with anticancer drugs is less scientific and has less theoretical advantage than systemic treatment. In the use of anticancer agents the margin between the dosage that will kill tumor cells and that which will kill normal cells is narrow. Washing is so crude a method of applying a toxic drug that one wonders how the proper dosage could ever be achieved. Mechanical washing away of spilled cells may be a secondary effect which is advantageous whether or not anticancer drugs are used. It is noted that one of Dr. Schiebel's patients who was thus treated had a recurrence in the wound.

After nearly 70 years of "standard" treatment, which is based on theory more than scientific evidence, it behooves all present surgeons of the breast to adopt a

treatment as effective only when presented facts that it is superior, not just that it can do no harm.

JESSE MEREDITH, M.D.

THE DEATH CERTIFICATE

Recently the State Board of Embalmers and Funeral Directors commended a North Carolina physician for prompt completion of death certificates. It is the practice of this physician to complete the certificate upon the death of a patient at home and leave the certificate with the family to be available for the funeral director upon his arrival. A letter to the physician commented on his unusual and excellent cooperation, and expressed the hope that this practice might spread to other physicians in the state.

As every physician is or should be aware, Public Health Law Chapter 130, Article 46, specifies that the death certificate shall be executed within 72 hours of the time of death, unless a delay is granted by the Registrar. As we all know, many doctors are somewhat dilatory in complying with the law, a failing that puts a great burden upon the funeral directors. We can certainly all understand and appreciate their desire to obtain the signed certificate as soon and as easily as possible.

Some doctors hesitate to complete a death certificate in the home to be left with the family. A death in a hospital may be a different matter. Having certificates available in the hospital to be completed immediately and left for the funeral director should be no great problem. If an autopsy is to be performed, a temporary certificate may be completed and forwarded to comply with the law. The final certificate may be executed to confirm the results of the autopsy. Any help that may be given the funeral directors as well as the Vital Statistics Division of the State Board of Health by prompt completion of the certificates should not be withheld. The problem is likely to be greater in rural than in urban areas.

GEORGE T. WOLF, M.D.

A TOUR OF DUTY ENDS

The retirement of Dr. J. W. Roy Norton as North Carolina's Health Director marks the close of almost a score of years in that post—a decade that brought wide recognition to the man and boosted North Carolina to the forefront in public health. Elevation to the top office in many of the numerous organizations with which he had been associated, including the presidency of the American Public Health Association, attests to his capacity for administration. Some insight into the character of the man is revealed in a motto adorning his office: "If you want to get the best out of a man, you must look for the best that is in him."

The rigors of boyhood on a farm, athletic discipline, broad academic and medical education, and distinguished military service in two World Wars tempered this "man-in-a hurry" with the unfailing air of remarkable self-control. Vigorous frontal attack upon problems as they arose, and the vision and readiness to tackle unmet needs have characterized Dr. Norton's tour of duty. Dignified, strong of will, yet ever sensitive to the views of his colleagues and associates, Roy Norton has given the best of himself to the people of North Carolina.

J.S.R.

THE PUBLIC EXPOSURE OF LAWYERS

Most of us have friends in the legal profession and enjoy following, in the newspapers, the practice of those who are trial attorneys. When one meets them in the course of events it is not out of place to congratulate or console them, as the case may be, depending on newspaper accounts of how the trial came out. We should stop and think on the good fortune of the medical profession regarding publicity on cases in progress.

It is not hard to imagine the psychologic pressures which would be created if the medical profession were subject to the public scrutiny imposed on trial lawyers. Imagine a newspaper account of the entry of Mrs. Smith into the hospital, the results of her physical examination, laboratory tests

and x-rays, and then an account of her surgery, with comments from the scrub nurse, orderly, and visiting friends. In particularly interesting cases there would be descriptions of the physician's clothes, car, and so on. We recently had a taste of

this with the gallbladder procedure performed on President Johnson. Let's hope it will not start a fad at the local level; most of us lack the dramatic flair of the trial lawyer, and we don't have the backing of tradition in coping with the publicity.

The President's Page

THE HEALTH CAREER PROBLEM

Here in North Carolina we have a number of hospital beds that lie idle and unused because there are not enough Health Workers to provide the services necessary for their operation. Operating room suites have expensive space not providing service because personnel cannot be had to operate at capacity. For a number of years we have faced a problem of obtaining enough anesthetists, nurses, surgical technicians, aides, orderlies and others to utilize fully the available facilities. The need is becoming, and will become, no less acute. All hospitals are confronted with the problem of a shortage in health personnel - ranging from physicians and surgeons, and their helpers, to the dietitians and their helpers; from the administrator to his floor sweeper, and to those concerned with maintenance.

In addition to all the needed health workers, it is factually predicted that thousands of additional hospital beds will be needed, and these in turn will compound our need for additional trained people in the allied health fields.

Our educational processes have developed sophisticated appetites which can be satisfied only by the provision of services which meet the demands of their expectations. Health insurance is expanding. Welfare services, including free medical care for the poor (and not so poor) are growing. Costs of medical education are high and rising. Efforts toward diminishing infant mortality, preventing disease, prolonging life, are adding millions of elderly citizens to our population. New legislation to provide free hospital care and low-cost doctor insurance for all our older citizens will multiply the broad demand for health services.

New medical fields, beyond the imagina-

tion of even Jules Verne, now require innumerable trained people. Our projects of space and underwater exploration require physiologists and others with unusual capabilities, and we are left with expanding the services of those concerned with inhalation therapy, heart and kidney machine technicians, and even hospital computer operators. The columnist-economist, Sylvia Porter, writes that there are more than 3 million workers in the "health business," and that this is one of the most rapidly growing businesses in the Nation today. Our total health service labor force is the Nation's third biggest - exceeded only by agriculture and construction.

I understand that by the year 2000, just one generation away, the population of the United States will probably be 300,000,000—100,000,000 higher than it is today and 200,000,000 higher than it was in 1920. North Carolina will have its proportionate increase.

A die yet to be molded is to be cast, I fear, which will broaden the expectations of many people and cause them to make greater demands on the services than those in the health careers can provide. Physicians in North Carolina can have a significant influence in the development of a program which will bring modern medical care to our people. In recent years your Medical Society has been working with the North Carolina Hospital Association and other interested groups in the development of a recruitment program - Health Careers for North Carolina. This has been initiated to help relieve the critical shortage of personnel in health careers through a program of career information for students in Junior and Senior High Schools. This effort is meeting with some success. It is obvious

that it needs additional support. Not only does it need money, but it also needs the individual support of every doctor in the State.

Doctors have the opportunity of guiding many, many people into the privilege of service in health careers. And this challenge encompasses those who are old or young, man or woman, trained or untrained. In the unique role of physician, we can help guide, by collective effort, hundreds of interested folks into a career which will give them a feeling of accomplishment of a most satisfactory nature. Each doctor can consider himself a "recruiter" for a team which has a local and national team effort.

We can inform our patients who are looking for jobs of the action of the 89th Congress which provides financial support to institutions and individuals in expanding state and national efforts to meet the demands for services rendered by those in health careers. It voted a record total for the entire field of health - above and beyond the historic P. L. 89-97 and the new funds for medical research. Funds were appropriated to build, expand, and improve medical, nursing, and dental schools; to improve and expand medical and nurse teacher training; to build and improve medical libraries and community health centers; and to provide student loans and scholarships.

In addition to the federal effort directed toward non-physicians and nurses, an effort must be made at the state level to encourage high schools, vocational schools, junior colleges, and four-year colleges to offer many more courses and facilities to educate and train health workers.

Physicians have a daily opportunity to recruit prospective health field workers. We can direct our young people into spheres of activity in which their capacities for participation can best be used; our middle-aged women into a program in which, with reasonable training, they can serve; and our people beyond 65 years of age into useful and meaningful endeavors. We need to support an appropriate increase in wages for these people so that they will not be

diverted into less essential fields offering more generous compensation.

Be alert to talent wherever and whenever you see it, to the end that you interest competent people in Health Careers in North Carolina.

GEORGE W. PASCHAL, JR., M.D.

The U. S. ranks first among all nations in the prevalence of and mortality from heart and blood vessel diseases, the North Carolina Heart Association reports.

The human infant's heart begins to beat when it is only about an eighth of an inch long—when the embryo is still less than a month old—the North Carolina Heart Association says.

The human body contains a network of about 12,000 miles of arteries, veins, and capillaries, says the North Carolina Heart Association. This is approximately half the distance around the earth.

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CORRESPONDENCE

To the Editor:

I have been privileged to see a copy of the September issue of the North Carolina Medical Journal containing Dr. Wells' article on "Report of a Local Disaster," and I have brought it to the attention of the local Civil Defense Advisory Council. They have been similarly impressed with its excellence and I plan to describe the events related in the article to local governmental officials for such benefit as they may derive in preparing for a similar occurrence which I know "can happen here."

However, I would like to point out that in this instance Civil Defense could not have been involved *unless* specific prior arangements had been made for Civil Defense participation in Air Show safety measures. If such had been done it was not evident from the article. Civil Defense has primary responsibility in event of an attack upon this country, or in event of a *very large* natural disaster. A single incident involving one airplane crash and fourteen injuries, however regrettable, would not seem to have been a situation permitting involvement of Civil Defense.

Incidentally, in this city a number of rather large scale exercises have been staged, usually involving all three hospitals. During 1965, in one exercise we simulated the explosion of a plane carrying a Krypton-85 bomb which caused 85 casualties, and in another, we assumed that a tornado had touched down at two sites with resultant 150 dead and injured.

HAMILTON W. Howe Civil Defense Director Winston-Salem and Forsyth County

The U. S. pharmaceutical manufacturers paid \$375 million in federal taxes in 1964, an amount in excess of the total voted in 1965 by Congress for the National Cancer Institute (\$158.6 million), the National Heart Institute (\$136.4 million), and the National Institute of Allergy and Infectious Diseases (\$77.9 million).

Americans will buy about \$60 million worth of appetite control drugs this year.

REPORT ON THE ACTIONS OF THE

House of Delegates American Medical Association

NINETEENTH CLINICAL CONVENTION NOVEMBER 28 - DECEMBER 1, 1965 PHILADELPHIA, PENNSYLVANIA

"Usual and customary" fees and prevailing fees, abortion and sterilization, billing and payment for medical services, membership dues, organization of the House of Delegates, and federal health care laws were among the major subjects acted upon by the House of Delegates at the American Medical Association's 19th Clinical Convention held Nov. 28-Dec. 1 in Philadelphia.

The House elected Dr. Drew M. Peterson of Ogden, Utah, to fill an unexpired term on the Council on Medical Service.

"Usual and Customary" and Prevailing Fees

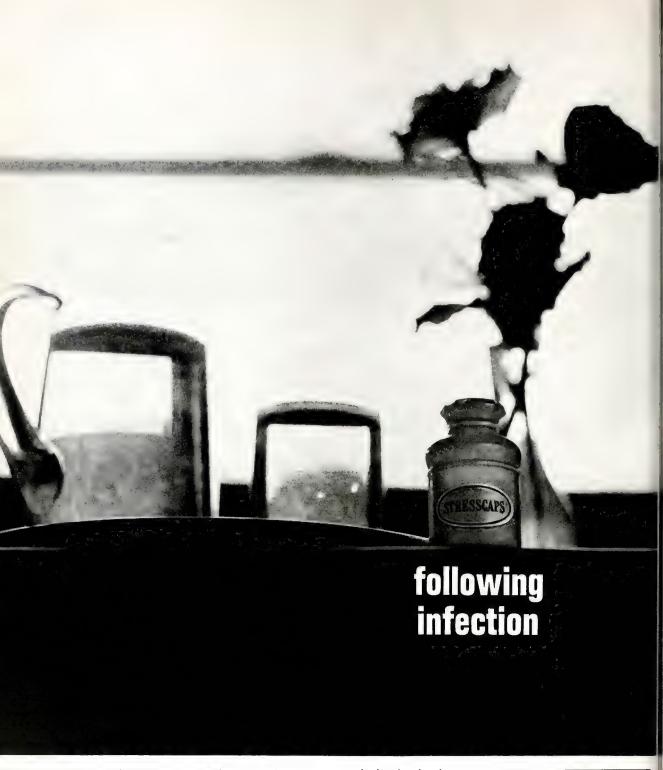
One of the most controversial issues before the House and the Reference Committee on Insurance and Medical Service was the "usual and customary" fee concept and the prevailing fees program of the National Association of Blue Shield Plans.

The House reaffirmed its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in government programs at all levels of government. It also urged "the individual physician's usual and customary fee concept to all third parties."

It took this action after modifying a Board of Trustees' report on the new "prevailing fees" program of NABSP. The modified report recommended:

"That the concept of the prevailing fees program of the NABSP be noted as one of the methods of compensation in those regions where the prevailing fees program is approved by the local or state medical society."

In its report, the Board recalled a statement adopted by the House at the 1965 Annual Convention, which recommended that when government assumes financial responsibility for an individual's health



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care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care.

"Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of 'usual and customary' fees," the statement said.

Abortion and Sterilization

Recommendations for the enactment of legislation to legalize abortion and sterilization under certain conditions were referred to the Board for further study. This action was taken after the House had received a report from the Board containing the recommendations of the Committee on Human Reproduction.

The House concurred in the reference committee's report that "it is not appropriate at this time for the AMA to recommend the enactment of legislation in this matter (abortion) for all states. The problem is essentially one for resolution by each state through action of its own legislature."

It also endorsed a statement that "appropriate legislation be enacted, wherever necessary, so that all physicians may legally give contraceptive information to their patients, consistent with the policy statement of December, 1964, and with the judgment and conscience of each individual physician."

Billing and Payment for Medical Services

Eight statements on fees charged by physicians for medical services were affirmed by the House. These are applicable "irrespective of whether such fees are paid by the patient, or paid or reimbursed in whole or in part under Public Law 89-97, or any other third party plan," the House stated. Here are the eight statements:

- "1. The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.
- "2. It is the patient's responsibility to deal with third party carriers in the area of financial assistance provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.
 - "3. The physician-patient relationship is served

best when there is an advance understanding regarding the payment of fees and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.

"4. The American Medical Association does not approve of any program which may directly or indirectly promote the charging of excessive fees or which interferes with the physician's right to charge fees commensurate with the services he renders.

"5. The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.

"6. It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also, any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the professional. (The foregoing is from a report of the Council on Medical Services to the House of Delegates at the Clinical Meeting in 1954).

"7. The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. (The foregoing is from a report of the Judicial Council which was approved by the House of Delegates at the Clinical Meeting in 1960.)

"8. It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession. (The foregoing is from an opinion of the Judicial Council in 1958.)."

Membership Dues

A \$25-a-year increase in membership dues, effective Jan. 1, 1967, was endorsed by the House when it was informed by the Board that additional income will be needed by then to avoid deficit spending.



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possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very have been reported. More severe and very

rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (I fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulesytesis thromboxylogenic nursura should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive merobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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The increase, to \$70 a year for the AMA's 165,000 dues-paying members, will go before the House for final action at the 1966 Annual Convention because AMA Bylaws state that annual dues may be prescribed by the House only for the ensuing calendar year.

Board Chairman Percy E. Hopkins, M.D., told the House that "during 1964 and 1965, the AMA will have incurred an operating deficit of more than 1 million dollars." The budget for 1966, he said, is now narrowly in balance.

The 1966 budget calls for spending some 27.6 million dollars, Dr. Hopkins reported, including almost 10½ million dollars on scientific programs, 5 million on health education and other medical service programs, more than 1 million to maintain physician records, and another million in the communication's program. Travel and meeting costs will exceed 2 million dollars.

"In a society," Dr. Hopkins said, "which has adopted inflation as a national policy and in which our system of medical care has become a pawn of politicians, it is not realistic to expect that we can limit tomorrow's programs to yesterday's income. Already demands are mounting from medical societies and physicians for a stronger and more effective AMA. These needs must be met and they must be adequately financed."

Federal Health Care Laws

The House took a number of actions with regard to federal health care laws passed in 1965, such as PL 89-97 (Medicare) and PL 89-239 (the Heart Disease, Cancer and Stroke Amendments). These actions included:

- —"That the AMA immediately seek remedial action to delete the requirement in Public Law 89-97 that a patient be hospitalized to establish eligibility for nursing home care."
- —"That the AMA immediately seek remedial action to amend Public Law 89-97, Part B, Title XVIII, by deleting the word 'receipted', from Section 1842 Part 3, Item B, line (ii), and substituting 'such payment will be made on the basis of a method of payment so arranged to preserve and continue the profession's current practice of

billing." Also approved "that the AMA recommend that the Department of Health, Education and Welfare establish that an agreement for payment between the patient and physician constitutes valid evidence of services rendered."

—Endorsed the Council on Medical Services' recommendation "that the state and local medical societies be urged at this time to assume leadership in the establishment of local advisory committees" under the Heart Disease, Cancer, and Stroke Amendments of 1965. The House noted that a National Advisory Council under PL 89-239 already has been appointed by federal officials and that the AMA was not given an opportunity to recommend possible appointees to the Council. "Therefore," the House declared, "active physician participation at the state and local levels is of utmost importance."

—Declared that the AMA Advisory Committee on PL 89-97 and 89-239 should persist in its efforts to achieve "practical recognition" by HEW of the differences between utilization review and claims review. The House adopted a report of the Council on Medical Service which said that "widespread confusion exists between the utilization review function and the claims review function." It also adopted a series of recommendations in the report aimed at clearing the confusion.

Other Important Actions

A study committee established by the Board of Trustees to evaluate planning techniques and development was approved by the House. The committee was given the tasks of (1) reviewing and studying current planning procedures in AMA, and (2) studying and recommending new mechanisms for organizational arrangements to achieve more effective planning and development in the future. Membership on the committee includes five Board members, the chairmen of the Councils on Medical Service, Medical Education, and Legislative Activities, the Speaker of the House, and two House members selected by the Speaker.

The House repeated a previous policy

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\$10,000 Major Hospital Policy

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Business Expense Policy

ANNUAL PREMIUMS*

AMOUNT OF MONTHLY				
OVERHEAD EXPENSE	Under Age 55	55-59	60-64	65-69
\$1,000.00	\$200.00	\$250.00	\$300.00	\$400.00
900.00	180.00	225.00	270.00	□ 360.00
800.00	160.00	200.00	240.00	□ 320.00
700.00	140.00	175.00	210.00	□ 280.00
600.00	120.00	150.00	180.00	240.00
500.00	100.00	125.00	150.00	□ 200.00
400.00	80.00	100.00	120.00	□ 160.00
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statement urging the creation of a separate post in the Cabinet of the President of the U. S. for a Secretary of Health.

Contributions totaling more than \$463,000 were presented to the American Medical Association Education and Research Foundation.

These were: \$203,655 from the California Medical Association, \$189,000 from the Illinois State Medical Society, \$45,000 from the New Mexico State Society, \$15,610 from the Utah State Medical Association, \$9,605 from the Medical and Chirurgical Faculty of Maryland, and \$510 from the Woman's Auxiliary to the Clackamas County, Ore., Medical Society.

Bulletin Board

Coming Meetings

Duke University School of Medicine and the American Academy of Orthopedic Surgeons, Postgraduate Cruise Course on Fractures and other Injuries - MS Europa from New York, March 14.

Bowman Gray School of Medicine of Wake Forest College, Postgraduate Course in Obstetrics and Pediatrics - Winston-Salem, April 12-14.

North Carolina Chapter, American College of Surgeons Meeting - Robert E. Lee Hotel, Winston-Salem, April 14-16.

Medical Society of the State of North Carolina, 112th Annual Meeting - City Auditorium, Asheville, April 30 - May 4.

North Carolina Heart Association, 17th Annual Meeting - Jack Tar Hotel, Durham, May 18-19.

American College of Physicians, Postgraduate Course, Neurology for the Internist - Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, June 15-18.

Spring Congress on Ophthalmology and Otolaryngology - Gill Memorial Ear, Nose, and Throat Hospital, Roanoke, Va., April 4-8.

NEW MEMBERS OF THE STATE SOCIETY

Drs. John Scott Miller, Jr., I, Western North Carolina, Black Mountain; Thomas Alexander Reading, 14 W Doctors Bldg., Asheville; Dr. William James Wheeler, Oph, 910 N. 4th St., Wilmington; Nathanial Louis Sparrow, 1300 St. Mary's St., Raleigh; Abner Carr Withers, GP, Box 488, Drexel; Benson Reid Wilcox, UNC School of Medicine, Chapel Hill; Marjorie Fisher Matthers, GP, Box 725, Pilot Mountain; David Charles McElroy, Anes, Lumberton.

NORTH CAROLINA CHAPTER AMERICAN COLLEGE OF SURGEONS

Dr. Howard A. Patterson, president of the American College of Surgeons, will be returning to his home town and state when he comes to participate in the meeting of the North Carolina Chapter of the American College of Surgeons to be held in Winston-Salem, April 14, 15, and 16.

A native of Salem, which he describes as "the pretty little town that was taken in to help make Winston-Salem," he was graduated from the two-year medical school of the University of North Carolina before transferring to Harvard to obtain his M.D. degree. As clinical professor of surgery at Columbia University and chief surgeon at Manhattan's Roosevelt Hospital, he now combines academic and clinical medicine, with the latter perhaps holding a slight edge.

Headquarters for the North Carolina Chapter meeting will be the recently renovated Robert E. Lee Hotel. Program chairman is Dr. Richard T. Myers of Winston-Salem, who has announced the following tentative schedule of scientific and business sessions.

Thursday, April 14

T - 14T -	
6:00 to	7:00 Social Hour
	Friday, April 15
A.M.	
8:30	Movie: Carcinoma of the Cemum
	and Ascending Colon.
9:00	Snake Bite - Dr. George Podgorny
	Winston-Salem
9:20	Tetanus - Dr. George W. Paschal
	Jr., Raleigh
9:40	Discussion
40 00 1	40.00 G 1 TH 0.1 G 1

10:00 to 12:00 Symposium: Diseases of the Colon (Moderator, Dr. Howard A. Patterson, New York City).

clair, Raleigh
Diverticulitis - Dr. Max Schiebel, Durham
Polyps - Dr. Russell Lyday,
Greensboro

Carcinoma - Dr. Gordon Sin-

P.M.

12:30 to 1:45 Luncheon

2:00 to 4:00 Panel Discussion, Current Areas of
Interest of The American College
of Surgeons - Moderator, Dr.
William F. Hollister, Pinehurst
Nursing Education - Dr. Alex
Webb, Jr., Raleigh
Medical Complexes - Dr. George

Medical Complexes - Dr. George Paschal, Raleigh

Residency Training in Community Hospitals - Dr. Addison Brenizer, Charlotte Guest Participant-at-Large - Dr. Howard A. Patterson, New York City

4:00 to 5:00 Business Meeting - Dr. Alexander Webb, Jr., presiding

6:00 to 7:00 Social Hour 7:00 Dinner

Saturday, April 16

A.M. 9:00

Movie: Thrombectomy for Ileo-Femoral and Avillary Vein Throm-

9:30 to 12:00 Symposium - Vascular Disease Moderator - Dr. Felda Hightower, Winston-Salem

> Cerebral Vascular Disease -Dr. Courtland Davis, Winston-Salem

Reno-Vascular Disease - Dr.
John Simmons, Chapel Hill
Aortic and Great Vessel Disease - Dr. A. Robert Cordell,
Winston-Salem

Peripheral Vascular Disease -Dr. Frederick H. Taylor, Charlotte

Vascular Injuries Associated with Fractures - Dr. David Anderson, Winston-Salem

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The UNC-Duke Psychoanalytic Institute has become the first two-university training program for analysts in the U.S. to receive official Institute status.

Dr. Milton L. Miller, psychiatrist at the UNC School of Medicine and chairman of the UNC-Duke Psychoanalytic Training Committee, announced that the North Carolina program was granted provisional institute status at the mid-winter meeting of the American Psychoanalytic Association.

North Carolina now has the 20th officially recognized psychoanalytic institute in the United States, the fifth associated with medical schools and the only one associated with two medical schools.

Physicians with one year of internship training and at least one year of psychiatric residency training may apply for enrollment. Completion of three years of psychiatric residency training is required before graduation.

The institute's five training analysts are Dr. Miller, Dr. David Young and Dr. George Ham of UNC and Dr. Bernard Bressler and Dr. John Rhoads of Duke.

In addition, the institute faculty includes Dr. David Hawkins, Dr. Rex Speers and Dr. Virginia Clower of UNC and Dr. Sanford Cohen of Duke.

Early this year doctors in small isolated hospitals in Central and South America and across the continent of Africa may be taking part in a unique medical communications system. By means of a combination radio-telephone hook-up they will be able to consult with specialists at Duke University Medical Center on hard to manage cases.

The service will be called Project Med Aid (Medical Assistance for Isolated Doctors).

Its purpose will be to bring expert and instantaneous consultation about the latest in diagnosis, treatment, and prevention of diseases to doctors working in field stations, mission outposts, and jungle hospitals.

The project will be supported for two years by a \$25,000 grant from the Mary Reynolds Babcock Foundation in Winston-Salem.

It will be carried out by the Division of International Health, Department of Preventive Medicine at Duke. The project director will be Dr. E. Croft Long, assistant dean at the medical school.

The station will be operated by members of the Duke Medical Center Amateur Radio Club, headed by Joseph P. Edwards, supervisor of central services in the College of Engineering.

Club members will be on the air between 9 a.m. and 5 p.m. seven days a week. Duke specialists will be able to talk to their distant colleagues without leaving their offices by using local telephone lines connected to the radio station.

Dr. Long said that telephone links with other medical centers are planned in the event the necessary consultants are not available at Duke.

of:

A program to train physician-scientists—persons taught from the start to view patients both as sick people and as scientific problems—will be launched at Duke University Medical Center this year under a \$138,000 grant from the National Institute of General Medical Sciences.

The program is intended to develop research competence simultaneously in both the medical sciences and the basic physical and biologic sciences.

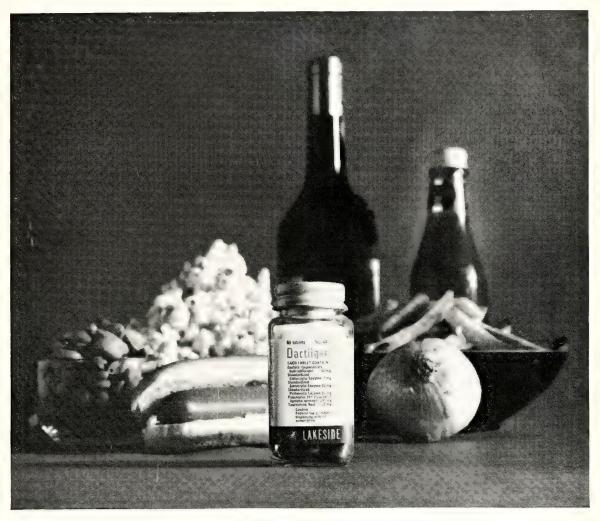
The curriculum is being designed to offer students a combined M.D.-Ph.D. program over a six- to seven-year span. The program will enable them to acquire a medical and scientific background tailored to their own needs and special interests.

Duke University School of Medicine and the University of San Carlos School of Medicine, Guatemala, have become affiliated in a program designed to further health-related education and research.

7(7

Faculty members from Duke will be invited to the San Carlos school, the second oldest university in Latin America, as researchers, teachers and consultants. At the same time, post-doctoral training and research in the basic sciences will be offered at Duke for faculty and students from Guatemala.

Dr. E. Croft Long, assistant dean in charge of student affairs at Duke, said the new program establishes what he calls "a partnership of equals." The Duke University School of Medicine will work



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DACTILASE: Each tablet contains: Dactil[®] (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylo-

lytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg. *Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

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Supplied: Bottles of 60 and 250.



with governmental and private agencies in this country to explore the possibility of obtaining funds to help the Guatemalan school improve teaching resources by supplementing its educational and research equipment.

Under the terms of the affiliation, Duke will also help its new partner in medical education and research expand its library facilities by making available duplicate books and journals.

Dr. Delford L. Stickel, 38-year-old assistant professor of surgery at Duke University Medical Center, has been appointed chief of the surgical service at the Veterans Administration Hospital in Durham.

He succeeds Dr. Raymond W. Postlethwait, who has been promoted to chief of staff at the VA Hospital.

Although his office will now be located at the VA Hospital, Dr. Stickel will continue to carry out his duties at Duke in teaching, patient care, and research.

Dr. Stickel is principal investigator, along with Dr. Bernard Amos, Duke immunologist, in a project seeking to overcome the major barrier to successful transplantation of vital organs—the rejection by recipients of tissue implanted from a donor. As one of the principal investigators in this research, he heads transplantation surgery, immunology, medical renology, and urological surgery.

Duke University Medical Center has established its first full professorship in bio-mathematics with the appointment of a nationally known mathematician and computer expert, Duke Provost R. Taylor Cole announced recently.

:4:

He is Dr. Max Woodbury, an adviser to the World Health Organization, a consultant to the National Bureau of Standards, and a former member of the President's Advisory Committee on Weather Control and the National Science Foundation's panel on weather modification.

Dr. Woodbury comes to Duke from New York University, where he has been professor of experimental neurology and head of the school's communication science section since 1962.

Mathematics and science have long been closely related, but only since the advent of computers has mathematics begun to play a role in medicine, especially in the field of medical research.

Dr. Jack Goodrich, formerly of the University of Mississippi Medical Center, Jackson, Miss., has been appointed as associate professor in radiology and head of the division of nuclear medicine at Duke University Medical Center, Duke Provost R. Taylor Cole announced recently.

The division of nuclear medicine is part of the radiology department headed by Dr. Richard G. Lester.

As chief of the division, Dr. Goodrich will con-

duct teaching, clinical and research programs related to radioisotopes. In the next year, the division is expected to double its physical plant facilities in order to provide better treatment for the increasing number of patients in the radiology department.

An individual and intellectual concept of the practice of hospital administration is offered in a book just published by Ray E. Brown, professor of hospital administration at Duke University Medical Center.

Entitled "Judgment In Administration," the book examines the role of judgment in administration and the nature of the judgment process.

Professor Brown, a nationally known authority and consultant in hospital administration, believes that hospital administration is a learnable art, a thinking man's game.

Good judgment, he maintains, is a natural product of the judgment process and bad judgment occurs because of interference with this process. The book concerns itself with the causes of failure in administration rather than with the causes of success.

A prolific writer on the subject of hospital administration, Professor Brown also is director of Duke University's Graduate Program in Hospital Administration. He recently was winner of an award for outstanding writing in the field of hospital administration from the American College of Hospital Administrators.

Five faculty members of the Duke University Medical Center have been promoted to the rank of professor, four others to associate professor, and six to assistant professor.

Dr. Joseph W. Beard, who has been James B. Duke professor of surgery in charge of experimental surgery and associate professor of virology, retains his James B. Duke professorship and also becomes professor of virology.

Dr. John W. Moore, also promoted to the rank of professor, conducts research largely in the field of neurophysiology and is using mostly marine organisms in his biologic studies.

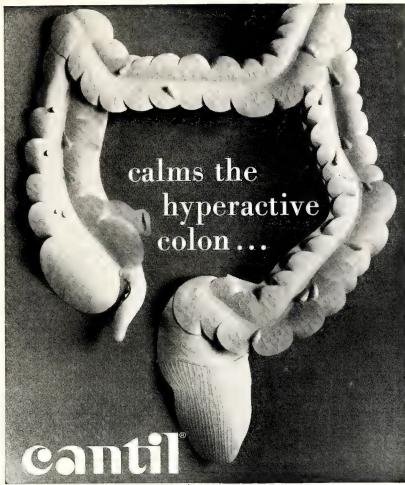
Dr. James B. Sidbury has been an associate professor of pediatrics and director of the clinical research unit at Duke since 1961. He is now professor in pediatrics and retains his directorship of the research unit.

A native of Havana, Cuba, Dr. Jacinto J. Vazquez has been promoted to professor of pathology.

Dr. Kenneth Cuyler is promoted from associate professor of cytology and anatomy to professor of obstetrics and gynecology and associate professor of anatomy.

Named associate professor were Dr. Athos Ottolenghi (pharmacology), Dr. John V. Salzano (physiology), Dr. Joachim R. Sommer (pathology), and Dr. Benjamin Wittels (pathology).

The new assistant professors are Dr. Irwin Brody



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IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withholdinglaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957



(neurology), Marion C. Crenshaw (obstetrics and gynecology), William K. Johnston (pathology), Demmie G. Mayfield (psychiatry), and George D. Wilbanks (obstetrics and gynecology).

Eight faculty members in the department of biochemistry at Duke University Medical Center have been promoted to the rank of full professor.

Announcement of the promotions was made by Dr. Douglas M. Knight, Duke president.

The new professors, all elevated from the rank of associate professors, are Dr. Mary L. C. Bernheim, Dr. Eugene A. Davidson, Dr. Robert L. Hill, Dr. Henry Kamin, Dr. Ralph E. Thiers and Dr. Salih J. Wakil, all former associate professors of biochemistry; Dr. Samson R. Gross, formerly associate professor of microbiology; and Dr. Walter R. Guild, formerly associate professor of biophysics.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Six out-of-state medical specialists participated at UNC on December 4 in a special program honoring Dr. Robert A. Ross, who is retiring as chairman of the Department of Obstetrics and Gynecology at the University of North Carolina School of Medicine.

The Robert A. Ross Obstetrical and Gynecological Society conducted its first formal meeting December 3 and 4. The society was formed earlier this year by 25 former resident physicians and faculty and house staff in Dr. Ross's department.

At a banquet December 4 the society presented to the University of funds to endow a Robert Alexander Ross Professorship in Obstetrics and Gynecology. Eighty per cent of a \$150,000 goal had been raised.

Local participants in the program were Dr. W. Reece Berryhill, former UNC medical dean; Dr. Isaac M. Taylor, present UNC medical dean; Dr. H. Fleming Fuller of Kinston, and Dr. John R. Kernodle of Burlington.

A locally constructed device which makes rapidly vibrating vocal cords appear motionless or almost motionless is being used successfully by throat specialists at UNC to detect early changes in the nerve supply to the larynx.

These early changes may be caused by such problems as minor strokes, enlargement of the heart or cancer of the neck and chest.

Dr. Newton D. Fischer, head of the Division of Otolaryngology at the University of North Carolina School of Medicine and N. C. Memorial Hospital, said that high-speed cameras weren't practical for the task "so we improvised a long known trick — the stroboscope."

A stroboscope emits a rapidly flashing light of

"The purpose of our investigation," according to short duration. When the frequency of the flashing light matches the frequency of a revolving or vibrating object, the moving object seems to stand still.

The instrument being used medically here was fashioned by Mack Preslar, a research associate in the Department of Surgery, from a surplus stroboscope.

With the stroboscope, Dr. Fischer is confident that early cancer of the larynx can be spotted before a patient's vocal cords become grossly paralyzed.

The homemade device is proving to be more than a diagnostic tool. It also detects signs of healing - - "early return of function" - - after surgery.

Studies leading to careers in medicine and dentistry were discussed for high school and university students at UNC recently at the annual undergraduate and freshman orientation meeting sponsored by Alpha Epsilon Delta, international premedical and predental honor society.

Four speakers talked about medical and dental schools and answered questions.

Your brain's remarkable capacity to file away enormous amounts of instantly available information continues to baffle scientists.

How, and in what form, do you store memories of early childhood?

Why is it that you can learn something but can't seem to remember it?

Or what happens to your ability to file away new memories while old memories seem to linger on indefinitely?

The basic nature of how you deposit learning in your brain's memory bank - - for instant withdrawal when needed - - has yielded so far only to scientific speculations.

At the University of North Carolina here, in the departments of biochemistry and psychology, a research team is wrestling with the mysteries of memory.

The team is directed by Dr. John Wilson and Dr. Edward Glassman, biochemists, and Dr. Kurt Schlesinger, psychologist.

"No one knows what memory really is," Dr. Schlesinger pointed out, "but we're trying here to gather enough facts to develop a coherent theory."

The researchers here strongly suspect that the first step in laying down memory in the brain is a complex chemical process initiated when genes are triggered to make RNA (ribonucleic acid).

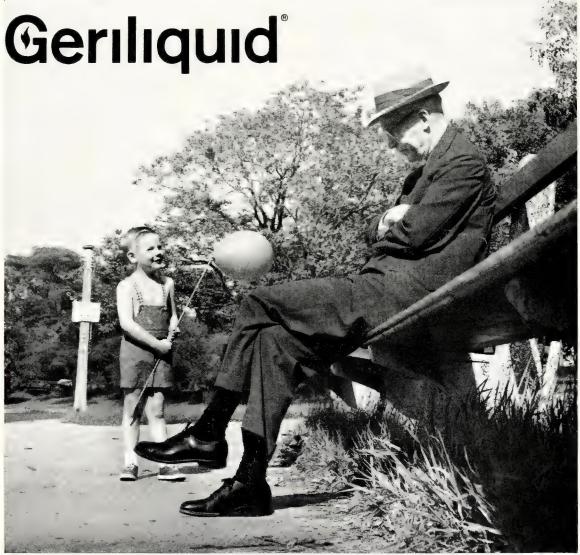
The RNA, in turn, directs the making of proteins in the nerve cells of the brain. The proteins, in some unknown way, are involved with memory storage.

Few studies of learning and memory have attempted to find out what type of RNA is involved in learning.

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IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%. Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

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Dr. Wilson, "is to attempt to ascertain whether RNA synthesis is involved in memory formation and to attempt to correlate memory with chemicals in the nervous system."

* * *

Contrary to popular belief in diet-conscious America, a moderately large amount of cholesterol in your blood doesn't lead to an early death from heart disease.

"Blood cholesterol probably doesn't really matter unless it's very high, perhaps four times normal," Dr. John B. Graham, pathologist at the UNC School of Medicine, said recently.

"Twice the normal amount doesn't seem to make any difference."

Dr. Graham reported on a research study which suggests that the current concern about cholesterol and heart disease has been exaggerated greatly.

His comments to the Elisha Mitchell Scientific Society at UNC described a genetic, biochemical and clinical study of "pure hypercholesteremia" in four generations of a nine-generation family from rural Eastern North Carolina.

The study by Dr. Graham, Dr. William R. Harlan, Jr. of the Medical College of Virginia and Dr. E. Harvey Estes of Duke Medical Center identified 79 of more than 1,000 members of the family as having twice the normal amounts of blood cholesterol.

These elevated cholesterol levels resulted from an abnormal gene in some of the family members.

In addition to doubling the blood cholesterol, family members with the abnormal gene also had cholesterol deposits under the eyes and masses of cholesterol on the knuckles of the hands and the tendons of the feet.

Dr. Graham said the study uncovered no evidence that persons with excess cholesterol died any earlier than other members of the family.

But Dr. Graham hastened to add that his conclusions apply only to people with elevated cholesterol and normal triglyceride levels.

"I would not want my results to be interpreted as suggesting that middle-aged people can now eat voraciously and cease exercising," he said.

Dr. Charles E. Rackley, 32-year-old native of Burlington, will join the UNC medical faculty on January 1 as assistant professor of medicine.

He has been an associate in medicine at Duke Hospital in Durham for the past year. Previously he was a Fellow in Cardiology there for a year.

Dr. Rackley received his medical degree from the Duke University School of Medicine in 1958 and served his internship and first-year residency in medicine at Duke Hospital.

During the following three years he was a second-year resident in medicine, a research fellow in cardiology and chief medical resident in medicine at the University of Washington in Seattle.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

A postgraduate course in obstetrics and pediatrics will be held at the Bowman Gray School of Medicine April 12-14 under the joint sponsorship of the medical school and the Maternal and Child Health Section of the North Carolina State Board of Health.

The program on obstetrics, starting at 9 a.m. April 12, will include two symposia — one on "Labor" and the other on "The Adolescent Patient." The session on pediatrics will begin at 2 p.m. April 13.

Co-directors of the course are Dr. Frank R. Lock, professor and chairman of the Department of Obstetrics and Gynecology, and Dr. Weston M. Kelsey, professor and chairman of the Department of Pediatrics. The guest faculty includes Dr. Charles Hendricks, professor of obstetrics and gynecology at Western Reserve University.

High frequency sound, already being used to study the internal structure of the human body, may also prove to be a valuable tool for studies on biologic function.

This possibility is indicated by research being conducted by Dr. William M. McKinney, assistant professor of neurology at the Bowman Gray School of Medicine. He is investigating the use of ultrasonic scanning techniques for observing and measuring motion within body structures.

His research involves the pulsation of blood vessels and cavities inside the skull. Designed to provide a comprehensive evaluation of these pulsations, the project will be supported for a two-year period by a \$28,000 grant from the National Institutes of Health.

Previous work in the young field of medical ultrasonics has dealt principally with the detection and identification of soft tissue structures deep within the body. But results from preliminary function studies at Bowman Gray and in sonics laboratories in Holland and Sweden add an important new dimension to the diagnostic potential of high frequency sound.

The primary aims of Dr. McKinney's project are to determine the characteristics of intracranial pulsations, the variables that influence them, and the clinical significance of the pulsations.

Some three years ago researchers at the Bowman Gray School of Medicine began to consider the South American squirrel monkey as a laboratory model for the study of atherosclerosis.

Today the medical school has the largest squirrel monkey colony in the world. The colony's population stands at 800, double the number of the next largest colony.

The sudden rise in the popularity of this little

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: ACTIONS AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of Iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg, of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc, of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthraigia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

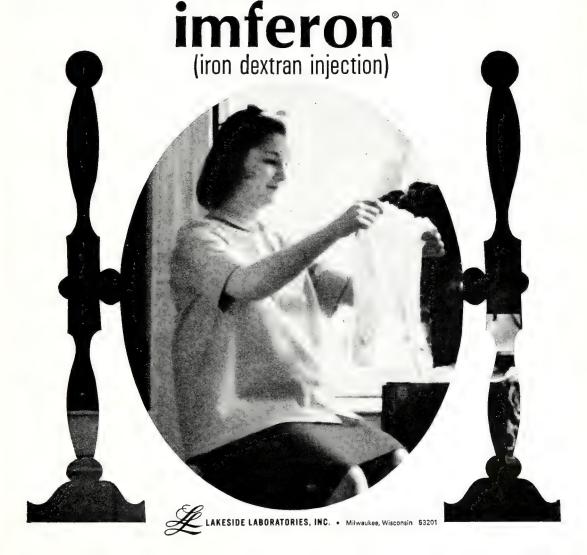
PRECAUTIONS: It sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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in iron deficiency anemia for rapid and predictable replacement of iron reserves



jungle creature, which weighs in at two pounds when full grown, is explained by its remarkable versatility. The structure and function of its biologic systems have proved to be highly suitable for research on a wide variety of medical problems.

Thirty-four scientists in 10 medical school departments are now using squirrel monkeys in projects that involve cardiovascular diseases, brain research, thyroid trouble, cancer, diabetes, reproductive problems, and behavioral studies. Their use in bone research is planned.

The research potential of the squirrel monkey is promising enough that a series of long-term studies have been initiated at Bowman Gray to find out more about the animals themselves. Dr. Thomas B. Clarkson, Jr., professor and director of the Department of Laboratory Animal Medicine, has been awarded a \$266,000 resource grant by the National Institutes of Health to support the work for a three-year period.

Dr. George S. Malindzak, Jr., assistant professor of physiology, has been appointed a Senior Research Investigator by the North Carolina Heart Association. His five-year appointment, which provides \$12,000 a year, became effective Jan. 1.

Dr. James F. Martin, professor of radiology, was recently appointed chairman of the membership

committee of the North Carolina Chapter, American College of Radiology.

Four papers, prepared in the Department of Medicine of the Bowman Gray School of Medicine, were presented at a meeting of the North Carolina Region, American College of Physicians, Dec. 9 in Chapel Hill. Appearing on the program were: Dr. John H. Felts, associate professor of medicine; Dr. Donald M. Hayes, assistant professor of medicine; Dr. Henry S. Miller, Jr., assistant professor of medicine; and Dr. Joel E. Futral, fellow in medicine.

Dr. Frank C. Greiss, Jr., assistant professor of obstetrics and gynecology, presented a paper entitled "Combined Radiation and Surgical Treatment for Carcinoma of the Uterine Cervix" at the Hahnemann Cancer Symposium Dec. 9 in Philadelphia.

Mrs. Eva S. Leake, research instructor in microbiology, participated in the second national scientific meeting of the Reticuloendothelial Society Dec. 8-12 in Salt Lake City, Utah. She presented a paper on "The Persistence of Intact Mycobacterium in Normal Alveolar Macrophages as a Consequence of Delayed Development of an Effective Digestive Vacuole."

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525 Bland St., Bluefield, W. Va. David M. Wayne, M.D. Phone: 325-9159

Charleston Mental Health Center

1206 Quarrier Street, Charleston, W. Va. Malcolm G. MacAulay, M.D. Phone: 344-3578

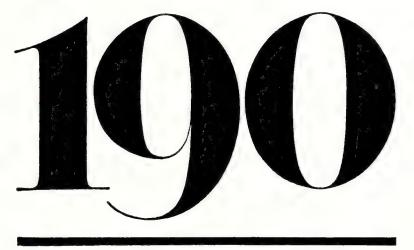
Beckley Mental Health Center

109 E. Main Street, Beckley, W. Va. W. E. Wilkinson, M.D. Phone: 253-8397

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Professional Building, Wise, Va. Pierce D. Nelson, M.D. Phone: 328-2211

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Dr. Frank R. Lock, professor and chairman of the Department of Obstetrics and Gynecology, spoke on "Marriage and Family Health" at a December meeting of the Florida State Obstetrical and Gynecological Society in the Bahama Islands.

Dr. I. Meschan, professor and chairman of the Department of Radiology, presented a refresher course entitled "Cerebral Arteriography and Venography" at the 51st annual meeting of the Radiological Society of North America in Chicago, Ill.

*

Two members of the Department of Radiology at Bowman Gray participated in a meeting of the Southeastern Chapter, Society of Nuclear Medicine, in Memphis, Tenn. They are Dr. C. Douglas Maynard, resident in radiology, and Richard L. Witcofski, instructor in medical physics.

Dr. Robert W. Prichard, professor of pathology, was the banquet speaker for the Roanoke Valley Heart Association's Cardiac Symposium Dec. 8 in Roanoke, Va. His address was entitled "Achieving Coronary Atherosclerosis." Dr. Henry S. Miller, Jr., assistant professor of medicine, presented a paper on "Clinical Diagnosis of Coronary Artery Diseases."

*

Two members of the medical school faculty presented papers at a meeting of the North Carolina Society of Pathologists Dec. 8-9 in Southern Pines. Dr. Robert P. Morehead, professor and chairman of the Department of Pathology, spoke on "Intermediate (Debatable or Controversial) Tumors." Dr. Robert S. Pool, assistant professor of pathology, presented a paper on "Diagnostic Problems in Dermatology."

Dr. R. Winston Roberts, professor of ophthalmology, presented three papers at the annual meeting of the Texas Ophthalmological and Otolaryngological Society Dec. 3-4 in San Antonio, Texas. His topics were "The Profile of the Early Glaucoma Case"; "Problems in Handling of Glaucoma"; and "Common Problems in Intraocular Surgery."

Dr. Clark E. Vincent, professor of sociology, spoke on "Sex and Marital Communication" at a meeting of the Academy of Medicine of New Jersey Dec. 1 in Newark, N. J.

Seventy scientists from a six-state area attended the annual meeting of the Southeastern Section, Society for Experimental Biology and Medicine Dec. 3-4 at the Bowman Gray School of Medicine.

The meeting included symposia on "Some Aspects of Lipid Metabolism" and "Biochemical Genetics," and a general scientific session. Eight of the papers presented at the meeting were prepared at the Bowman Gray School of Medicine.

NORTH CAROLINA HEART ASSOCIATION

Capt. George Bond of Bat Cave, now internationally famous for his work at the bottom of the sea, met with North Carolina Heart Association representatives in November, and, in the course of the discussions, disclosed the next step in the Navy's "inner space" research program.

Sealab III, an ocean-bottom laboratory, will be stationed at more than twice the depth of Sealab II, according to Capt. Bond. Sealab II was submerged at 205 feet below the Pacific Ocean surface off the California coast earlier this fall.

Capt. Bond stated that the United States is now spending only one cent for inner space research for every \$2.42 allocated to outer space research. He urged an accelerated national emphasis to the ocean bottom studies—"to give the man-in-the-sea goal the same national standing as the man-on-the-moon goal." The ocean's minerals and foods and ocean-bottom research applicability to medicine make inner space research a matter for priority national attention, he said.

The forthcoming Sealab III project was significant to the hyperbaric medicine conference because hyperbaric oxygenation, a likely procedure for the treatment of heart disease and many other diseases, involves pressure chambers similar to ocean diving bells in which the patient's blood is supersaturated with oxygen under high atmospheric pressures.

Tarboro Physician Volunteers for Project Viet-Nam

Among the latest group of American doctors to volunteer for two months' service in South Viet-Nam is Dr. J. Ralph Dunn of Tarboro. The group of ten general practitioners and surgeons were briefed on Dec. 10, in Washington, D. C., as to locations and assignments by Dr. Edwin H. Brown, associate medical director of HOPE and director of Project Viet-Nam. They sailed for Saigon the following day.

In a letter to presidents of state medical societies, AMA President James Z. Appel, M.D., has announced that the AMA is assisting the newly formed voluntary organization known as Project Viet-Nam. The project is designed to help alleviate the problem of the critical shortage of physicians in South Viet-Nam - a problem that is crippling and demoralizing the civilian population of the country.

Interested physicians may obtain further information and application forms by writing PROJECT VIET-NAM, 2233 Wisconsin Avenue, N.W., Washington, D. C. 20007.

Dr. Appel said, "I ask your help in the medical support of valiant people playing a decisive role in the defense of freedom, not only in Southeast Asia, but in all the world."



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METAHYDRIN°

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To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin* (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., et al: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

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SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

LOUISE OBICI MEMORIAL HOSPITAL Annual Clinical Congress

An award for "Outstanding Contributions to Medicine" will be made to Dr. Francis Bayard Carter of Duke University at the annual clinical congress of the Louise Obici Memorial Hospital to be held in Suffolk, Virginia, on Wednesday, April 6.

Because Dr. Carter is to receive the award, the program for the congress will be geared to his field of practice. The subject of the program is "Menopause: Its Problems - A Practical Approach."

Participants for the day will be Dr. Felix Wroblewski, Brookdale Hospital, Long Island, New York; Dr. William Sweeney, Cornell University and Brookdale Hospital, Long Island; Dr. John K. Frost, Johns Hopkins University; and Dr. Carter, who will serve as moderator.

SOUTHERN MEDICAL ASSOCIATION

Physicians elected to serve as officers of the Southern Medical Association for the current year included the following from North Carolina: Dr. William Banks Anderson, Sr., of Durham - chairman of the Section on Ophthalmology; Dr. John T. Sessions, Jr., of Chapel Hill - chairman of the Section on Gastroenterology; and Dr. William P. Wilson of Durham - secretary of the Section on Neurology and Psychiatry.

These officers will share the responsibility for arranging the program for their respective sections for the 1966 meeting of the association, which will be held in Washington, D.C., Nov. 14-17.

BLUE SHIELD PROVIDES FOR THE ELDERLY

Those who deride or ignore the efforts of voluntary health insurance plans in providing protection for those over 65 refuse to look at the facts. A look at the efforts of Blue Shield in providing such protection is most enlightening.

Blue Shield membership now includes more than 4 million persons past 65, better than 8% of the entire Blue Shield membership. In 1951, 1 million people, 5% of Blue Shield's entire membership, were over 65.

It is particularly significant that while total Blue Shield membership during the 18 months ending last December 31 increased approximately $5\frac{1}{2}\frac{9}{6}$, the number of persons over 65 covered by Blue Shield increased 21 per cent. Thus, the growth rate rate of coverage for those over 65 is nearly four times that of all other age groups combined.

In 1959, only 10 Blue Shield plans offered individual non-group membership without age limit. Today, 73 out of the 74 United States Blue Shield plans, representing over 99% of the total membership in this country, have available individual non-group coverage for persons over 65.

Apart from Blue Shield's progress in providing health insurance coverage on an individual basis to those over 65, a more significant development has been the increasing practice of both local and national labor and management groups to negotiate a provision in their health and welfare programs for the continued coverage of retired employees under the same arrangements and conditions as apply to their active employees.

A good example is the pattern adopted by the federal government for its retiring employees. Blue Shield, with Blue Cross, covers over 3,500,000 federal employees and their dependents. Each year, more than 25,000 retiring federal employees take their Blue Shield protection into retirement. These retired federal employees, like many retiring from private industry, are assisted by their former employer in continuing their health coverage.

Proponents of Medicare claim that figures on the number of persons over 65 covered by voluntary health insurance are misleading because in most cases only the barest minimal coverage is provided. Blue Shield spikes that theory by pointing out 65 of 73 Blue Shield plans pay for the entire cost of the medical-surgical protection of those over 65. The "paid-in-full" benefits apply to Blue Shield senior citizens even more completely than to members under 65.

Blue Shield realizes that those over 65 represent special health problems, as do the chronically ill, the handicapped, and the indigent. In these cases, Blue Shield brings the resources of the entire community to bear upon these special problems.

Blue Shield feels that the proportion of the over-65 population covered by voluntary health insurance will soon match that of the entire population, with the quantity and quality of coverage for all people regardless of age continuing to improve at a rapid pace.

U. S. PUBLIC HEALTH SERVICE

Awards of almost \$1 million in senior clinical traineeship grants to 91 physicians were announced recently by the Public Health Service.

The grants, which totaled \$971,500, will enable physicians who have completed resident training in specialty fields to obtain an additional year's training and experience in the prevention, diagnosis, treatment and the control of cancer.

Two of the grants were received by physicians training in North Carolina. They are Drs. Millie Ann Pitts Hancock and Miles Robert Cooper, both at the Bowman Gray School of Medicine of Wake Forest College.

Appointment of Dr. Carruth J. Wagner as Chief of the Bureau of Medical Services in the U. S. Public Health Service, was announced today by Surgeon General William H. Stewart. The appointment is effective immediately.

Dr. Wagner is an assistant Surgeon General and

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Adverse Effects: Side effects, usually mild, may

include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000. has been serving as Chief of the Division of Indian Health for the past three years. He succeeds Dr. Leo J. Gehrig who recently was appointed Deputy Surgeon General.

UNC One of Nineteen Medical Centers in USA to Study Life-Long Medical Records of Olympic Athletes

The Olympic Medical Archives (OMA) was conceived to improve the health of mankind throughout the world. World scientists have agreed that there is no better source of "maximum health" than the superfit young men and women gathered under the banner of the Olympic Games. A compilation of the life-long medical records - the Olympic Medical Archives - of many of the world's top athletes which will enable scientists to determine the long term effects of physical exercise on the health of man began with the 1964 Olympic Games in Tokyo.

Today, just a little over a year later, Dr. Joseph B. Wolffe, International Chairman of the OMA and medical director of the Valley Forge Medical Center and Heart Hospital, Norristown, Pa., reports that there are over 2,000 medical records and histories of athletes from some 20 countries filed in the OMA Library of the Olympic Museum in Lausanne, Switzerland. These standardized physical examinations and questionnaires on personal, family, social background and athletic training programs of athletes from Belgium, Canada, Ceylon, Chile, Cuba, Czechoslovakia, Finland, Great Britain, Ireland, Japan, Mexico, Nigeria, Philippines, Nepal, Rhodesia, Taiwan, Trinidad, United States of America, Uruguay, U.S.S.R., Venezuela, and Yugoslavia have been translated and coded on magnetic tape for electronic retrieval by qualified scientists and researchers.

In the past only sporadic investigations have been carried out on the effect of vigorous physical activity on man, which resulted in many contradictory conclusions in medical literature. With the aid of men like Dr. R. B. Lindsay, medical coordinator of the OMA in North Carolina, and the facilities offered by the University of North Carolina, it is hoped that the lifelong medical records of Olympic athletes will provide the answers to a number of medical questions with wide implications. These studies may well shed light on:

- 1) The extent to which continuous, systematic, lifelong vigorous physical activity prevents or retards the onset of some of the common diseases such as those of the heart and blood vessels, high blood pressure, chronic ailments of the joints and disturbances of the nervous system.
 - What types, duration and frequency of physical exercise are essential for maximum fitness.

3) What influence regular physical training has on longevity and morbidity.

Volunteer Corps for Science

Dr. Lindsey and his staff as well as other physicians, hospitals, medical and health organizations, Olympic contestants, their personal coaches, team coaches, trainers and participating members of the Olympic committees and sub-committees, have been enrolled in the OMA Corps, Volunteers for Science. This group - all volunteers - during the past year donated more than \$250,000 in time and service to promote the concept of the OMA.

The Olympic Medical Archives was developed by the American College of Sports Medicine, and the program is now under the auspices of its parent organization, the Federation Internationale de Medecine Sportive, with the cooperation of the World Health Organization, the International Olympic Committee and the International Sports Federation

The Executive Council of the Federation Internationale de Medecine Sportive (FIMS), which met in Magglingen, Switzerland, during the first week in October, recently announced that plans are underway to enlarge the scope of the Olympic Medical Archives through the 1968 Games to be held in Mexico City.

The Month In Washington

The staff of the Senate antitrust subcommittee has been investigating the rise in quinine prices.

The investigation resulted from receipt by members of Congress of complaints from constituents. Many of the complaints reported a sharp rise in the price of quinidine, a quinine derivative prescribed for irregular heart beats.

The Pharmaceutical Manufacturers Association attributed the price rise to a combination of decreased supplies and rising demands.

A spokesman for the association said that it had become increasingly difficult to obtain quinine's raw material, the bark of the Cinchona tree. He said that Indonesia, once the principal supplier, had virtually cut off its exports of the cinchona bark to the Western world.

Other suppliers, he said, include the Congo and some South American countries. He said these sources were seriously limited,

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February, 1966

but that the shortage was not expected to reach critical proportions.

The PMA spokesman attributed the rising demand to the appearance of new strains of malaria that are resistant to synthetic drugs developed during World War II as quinine substitutes. This has caused demands for natural quinine to rise sharply in such malaria-infested areas as Vietnam.

The Food and Drug Administration has taken the first steps in implementation of the new law designed to halt illegal traffic in depressant and stimulant drugs.

Acting FDA Commissioner Wilton B. Rankin announced proposed regulations and appointed an advisory committee of experts as authorized by the Drug Abuse Control Amendments law enacted last year.

The Advisory Committee on Abuse of Depressant and Stimulant Drugs, which held its first meeting in late December, assisted the FDA in determining the drugs covered under the new, tighter controls effective February 1, 1966. The new law specified amphetamines and barbiturates, but also authorized designation of other depressant and stimulant drugs by regulatory orders of the FDA.

At its first meeting, the advisory committee considered several classes of such drugs, including certain tranquilizers, LSD-25, and other hallucinogenic agents.

The FDA regulations listed details of the records which the new law requires to be kept by every person manufacturing, compounding, processing, selling, or otherwise distributing the designated drugs. The first required record is an inventory of stocks on hand of such drugs as of Feb. 1. This initial inventory must contain the identity and quantity of all the specified drugs in finished form under the control of the registrant. Records thereafter must accurately list further manufacture, receipt, and disposition of the drugs.

The system of record keeping was designed to permit government agents to follow the movement of the drugs—all of which are prescription drugs—from producer to consumer.

The FDA commissioner is authorized to determine that a stimulant or depressant drug has a potential for abuse, and therefore should be covered under the law, if there is evidence of:

—Individuals taking the drug in amounts sufficient to create a hazard to their health or to the safety of other individuals or the community.

—Significant diversion of the drug from legitimate drug channels.

—Individuals taking the drug on their own initiative rather than on advice of a physician or osteopath licensed by law to administer such drugs.

Most physicians won't be affected directly by the new federal regulations which state:

"The maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

A panel of leading businessmen has warned of the dangers of relying too heavily on government for administration of health and retirement plans.

Such government programs should be used to help the sick, disabled and aged, the panel said, "only if voluntary and private means—truly and tested—cannot adequately meet society's needs Heavy reliance on government can discourage the experimentation and innovation needed to solve our health and retirement problems. Such reliance also can narrow the freedom of choice of people who prefer to meet their needs in their own ways."

This statement was a highlight of a 263page report by the Task Force on Economic Growth and Opportunity, which was an independent group set up under the sponsorship of the U. S. Chamber of Commerce. The report was entitled "Poverty: The Sick, Disabled and Aged."

The report cited medicare an an example, as follows:

"In an attempt to help low income aged people obtain health care at little personal cost, medicare was attached to the traditionbound Social Security program. As a result, medicare will help millions of Americans who are not needy by any stretch of the imagination.

"It will be financed by the Social Security payroll tax, a highly regressive tax that places heaviest burdens, in relation to income, on low income workers and on low income consumers who pay higher prices to absorb the cost of payroll taxes levied on employers."

The incidence of measles in 1965 was the lowest in recent years, according to the Public Health Service's Communicable Disease Center.

Through the first 49 weeks of the year, 256-443 cases were reported, far below the average of more than 400,000 annual cases since 1960. There were 478,518 cases in the first 49 weeks of 1964.

But PHS warned that, if past experience is repeated, major epidemics can be expected in many sections of the country during the first half of 1966.

The federal government is going to spend more on health and education programs in 1966—but not as much as originally expected, principally because of the Viet Namwar.

HEW Secretary John W. Gardner says 1966 would not be a "slowdown year" in his department because of the start of new programs in elementary and secondary education, medicare, water pollution, disease control, and other areas.

But, he added, a certain slackening in other programs might be useful. He declined to identify specific projects. He said, however, that they "might be done better if they are started slowly."

Hunters should be certain they have the heart to hunt, says the North Carolina Heart Association. Among the hazards of hunting is accidental death from gunshot—one's own gun, or that of another hunter. Not so dramatic, but at least three times as prevalent, is the tragedy of heart attack deaths.



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February, 1966

In Memoriam

Charles Lamar Hunsucker, M.D.

Charles Lamar Hunsucker, son of J. W. and Alice Dellinger Hunsucker, was born in Catawba County November 17, 1891. After receiving an A.B. degree from Conover College in Conover, North Carolina, he entered the North Carolina Medical College at Charlotte, and was graduated from that institution with the degree of doctor of medicine in 1913.

Dr. Hunsucker began the practice of medicine at Drexel, North Carolina, but a few months later moved to Hickory and started a practice which spanned approximately 50 years in that locality. On September 30, 1913, he was married to Miss Fleta Moore of Hickory.

Dr. Hunsucker was widely respected in the area in which he practiced, and was adored by many of his patients. He was a most congenial and thoughtful person, and would do anything for his patient's comfort at any time, day or night. He had a host of friends in the community, and was an active member of the Reformed Church and a one-time member of the Hickory Kiwanis Club.

Much could be said regarding this man and his service to mankind. Those who knew him best were impressed by his ability to instill into his patients unbounded confidence in him.

WHEREAS, the Creator has judged that Charles Lamar Hunsucker's time was complete upon this earth, the Catawba County Medical Society, of which he was a member, does hereby,

Resolve, That a copy of this expression of regret at his passing be sent to his wife, Fleta Moore Hunsucker, and that a copy be sent to the Archives of the Medical Society of North Carolina, and that the original be entered into the records of the Catawba County Medical Society.

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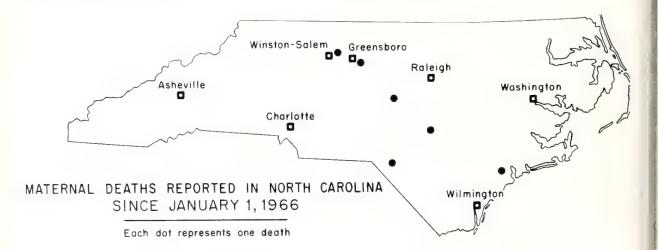
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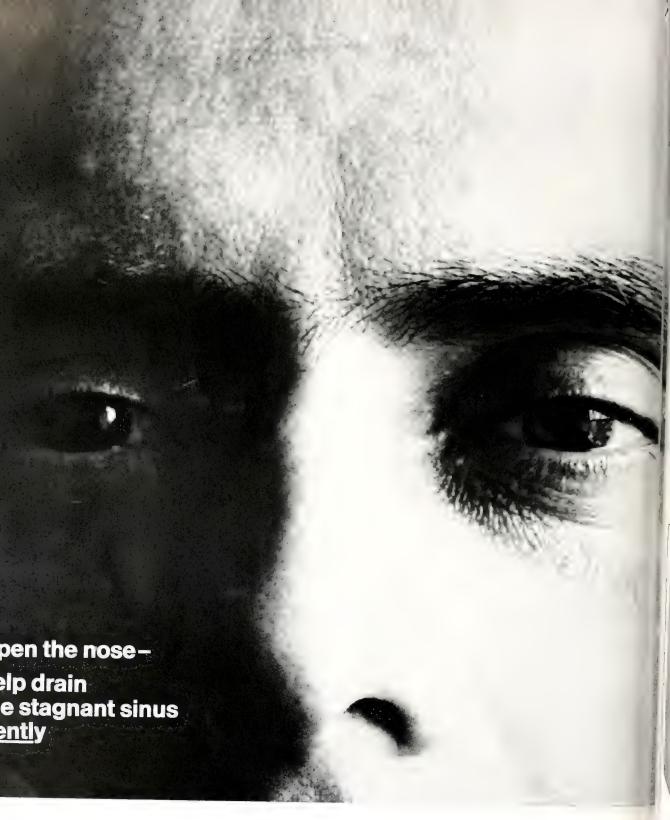
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Neuroblastoma: A Report and Review

Program of the 112th Annual Session

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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, III., Charles C Thomas, 1963, p. 34.

Winthrop Laboratories, New York, N. Y. 10016

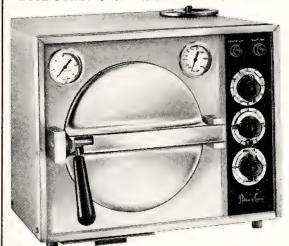
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MARCH, 1966

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Neuroblastoma:

Review of the Literature and Report of Eighteen Cases

LAMAR T. ADAMS, M.D. WINSTON-SALEM

Neuroblastoma ranks high among the malignancies of infants and children, being second only to leukemia. It is therefore the most common solid tumor in this age group.1 It is notorious for its rapid growth and spread, tending to metastasize early and widely. The earliest symptom is often referable to a secondary lesion rather than to the primary growth. The usual sequence is a rapid and steady downhill course, with death occurring in a few months after the diagnosis has been made. In contrast, the literature contains a few well documented cases of spontaneous regression of widespread tumors without any form of treatment. It is the purpose of this paper to review the literature briefly and present a series of cases seen at North Carolina Baptist Hospital during the ten-year period from 1955 through 1964.

Patient Material

Only those cases in which the diagnosis was confirmed by histologic study are included. Excluded are the cases in which the diagnosis was made on radiologic or clinical evidence without histologic confirmation; the cases diagnosed at another hospital when pathologic material was not available for review at this hospital; and those cases in which the pathologist was unable to determine without doubt the exact nature of the tumor—that is, "poorly differentiated malignant tumor consistent with neuroblastoma."

Utilizing the foregoing criteria, 18 cases were included in the review. All hospital

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charts were studied thoroughly, with special attention to the diagnosis, treatment, clinical course, and prognosis. In addition, referring physicians were consulted in some cases to obtain more details or more recent follow-up reports. Fifteen of the 18 cases were followed for at least two years or until terminated by death. Of the remaining three, two were lost to follow-up three months or less after diagnosis, and the third is a recent case which has been followed for only eight months.

An attempt has been made to correlate the findings in this study with information from the literature.

History

Virchow,2 in 1864, first described a neuroblastoma, although he classified it as a glioma. In 1891 Marchand³ noted the similarity of these tumor cells to the cells of the embryonic central nervous system. The clinical picture was described by Pepper4 in 1901 and by Hutchinson⁵ in 1907. Pepper described a primary adrenal tumor with liver metastases, and Hutchinson described a primary adrenal tumor with skeletal metastases, notably involving the skull. For many years neuroblastomas were classified into two types on the basis of these descriptions, the Pepper type being primarily adrenal-hepatic and the Hutchinson type primarily adrenal-skeletal in distribution.

In 1910 Wright⁶ concluded from studying the adrenal glands in embryos that these tumors must arise from the developing sympathetic nervous system. He proposed that they be called neurocytomas or neuroblastomas. Before this time they had generally been classified as gliomas or sarcomas.

Herxheimer,⁷ in 1914, first demonstrated that the fibrils characterizing the microscopic appearance of neuroblastomas were primitive nerve fibers and arose from the cells of the tumor. It was not until the early 1940s that Farber⁸ and Karsner,⁹ working independently, finally dispelled the Pepper and Hutchinson concepts of neuroblastoma and demonstrated that the site of metastasis bears no relationship to the cytologic nature or the primary site of the tumor.

Origin

Neuroblastomas arise from the primitive sympathetic neuroblasts (sympathogonia). The sympathetic nervous system originates from cells of the ectoderm of the neural crest. Early in embryonic life these cells migrate ventrally to form a syncytium from which develop the sympathetic chain and ganglia and the celiac plexus. Cells from the celiac plexus then migrate further to enter the mesodermal anlage of the developing adrenal gland to form the definitive adrenal medulla. These migrating cells (sympathogonia) ultimately give rise to two distinct adult cell lines, the ganglion cells and the chromaffin cells.

The chromaffin cells are responsible for the elaboration of the adrenal medullary hormones. Tumors of this cell line are of two types: the pheochromocytoma, which is hormonally active, and the paraganglioma, which is hormonally inactive. Both types may be distinguished from other tumors because they give a positive chromaffin reaction in the laboratory.

Tumors of the ganglion cell line, sometimes called non-chromaffin cells, are the neuroblastoma, ganglioneuroblastoma, and ganglioneuroma. The only distinction between these tumors is their degree of differentiation. The term "neuroblastoma" is generally used to include all malignant tumors of non-chromaffin (ganglion) cells irrespective of their degree of maturation, as distinct from ganglioneuroma, which is a mature, benign tumor arising from these same non-chromaffin cells. The term "sym-

pathicoblastoma" has been suggested to replace "neuroblastoma," since it is more meaningful, but this change has not been generally accepted.

Neuroblastoma is considered to be a rather typical example of a malignant embryoma; that is to say, it arises as a result of maldevelopment or dysontogenesis of embryonal cells. Dysontogenesis is manifested by a disturbance in the normal maturation or differentiation of the sympathogonia which results in the formation of the tumor mass. It is not known if these sympathogonia are essentially normal neuroblasts that have for some reason failed to differentiate properly, or if they have undergone malignant transformation.¹¹

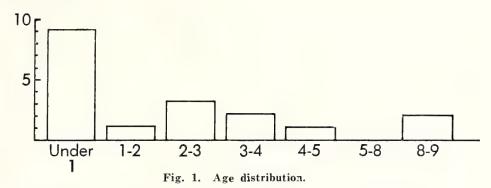
The occurrence of neuroblastomas in such a variety of anatomic locations other than the adrenal medulla is accounted for by the fact that the same embryonal neural-crest ectoderm gives rise to the spinal and sympathetic ganglia, the multipolar neuroblasts of the spinal cord and brain, and the periaortic bodies of Zuckerkandl. Apparently ectopia accounts for a primary tumor of this type in such unusual locations as skin and bone. Another possibility is that the neuroblastoma may be the only remaining evidence of what was once a teratoma, other components of which have for some reason ceased to grow.¹

Classification and Pathology

Attempts have been made to subdivide neuroblastomas into three subtypes depending upon their degree of differentiation. The literature is unclear on this point for two reasons. First, the tumor does not lend itself to further categorization, since a single tumor may contain both areas of poorly differentiated cells and areas of moderately well differentiated cells. Second, there are no accepted criteria for identifying these subtypes and the nomenclature is overlapping. Suffice it to say that the sympathicogonioma or sympathicoblastoma is the least differentiated, the neuroblastoma sympatheticum or sympathicoblastoma somewhat more so, and the ganglioneuroblastoma is the most differentiated.

Grossly these tumors vary greatly in size,





there being no correlation between size and degree of maturation, or between size and the presence of metastases.¹³ In the early stages of development, they are smooth and round, and range from a reddish-green to a reddish-gray in color, often with a violaceous tinge to the capsule indicative of their marked vascularity. As they enlarge they tend to assume a nodular appearance, and the tumors break through the capsule. The cut surface reveals a highly cellular, spongy, yellowish-gray tumor with focal necrotic and hemorrhagic areas. Invasion of blood vessels and infiltration into surrounding tissues are extremely common.

Microscopic examination discloses broad sheets or clusters of fairly uniform cells having dark-staining nuclei and little cytoplasm. There is scant stroma, and mitotic figures are common. The nuclei contain a moderate amount of chromatin, which is either dispersed evenly or arranged peripherally. In some areas there are rings of cells surrounding a central area of eosinophilic neurofibrillary processes. These are the "rosettes" or "pseudo-rosettes," the presence of which is considered pathognomonic. The least differentiated tumors may show only faint or poorly formed rosettes, while the more differentiated tumors may abound in them. As noted before, the microscopic picture may vary from one area to another of the same tumor, and it is not uncommon to find areas indistinguishable from a benign ganglioneuroma surrounded by areas of poorly differentiated cells. Calcification occurs with some frequency, as it does in other neurogenic tumors.

Incidence

Although neuroblastomas are embryonal in nature and therefore congenital, there is apparently no familial tendency. Rarely has more than one case been reported in a family. In one case included in the present series, a sibling of the patient died with a poorly differentiated malignant tumor, the exact nature of which could not be determined by biopsy but which was reported as either "neuroblastoma, retinoblastoma, or malignant mesodermal tumor."

The sexes are affected about equally. No racial predilection has been established, but Bennett,¹⁵ in his series of 26 cases from Cape Town, South Africa, reported 18 cases in white children and 8 cases in non-white children. He considered these cases to be representative of the general population, which has more than twice as many colored children as white.

Neuroblastoma is unquestionably a tumor of the very young. It has been observed in the stillborn fetus and not rarely is found incidentally at autopsy in infants dying within the first few days of life. One case included in this report occurred in a child who died 37 hours after birth. Cases have also been reported in adults as old as 53 years, 16 but this is the exception rather than the rule. Age ranges differ in different reports, but it would appear that about 60% of the cases occur within the first four and 80% within the first five years of life. In this series, 83% of the patients began to have symptoms before the age of 4 years. The oldest patient was 8 years 11 months at the time of diagnosis (Fig. 1).

Diagnosis

Location of tumor

Since the neuroblastoma can arise from any site where one would normally find elements of the sympathetic nervous system, the presenting symptoms will vary depending on the location of the tumor. The adrenal medulla is by far the most frequent site of origin. While in this series only 28% of cases could be definitely said to arise in the adrenal gland, 72% originated either in the abdomen or abdominal retroperitoneal chain (Fig. 2). In fairly large tumors, the exact site of origin often can not be definitely determined. The figure of 72% is in accord with figures quoted in the literature, but in most reported series a higher percentage of cases are stated definitely to arise in the adrenal medulla. In this series 11% of tumors were primary in the pelvis and another 11% arose in the thoracic sympathetic chain. In one case the tumor was so widespread at the time of diagnosis that no primary site could be determined.

In one interesting case the question of multiple primary tumors arose. This child presented at the age of 9 months with failure to thrive and an unexplained fever. Over a period of six weeks she evidenced increased intracranial pressure, and expired while a craniotomy was being performed. At autopsy she was found to have a neuro-

blastoma of the left adrenal medulla, another neuroblastoma of the left thoracic sympathetic chain, a papilloma of the choroid plexus, and poorly differentiated malignant tumor of the right adrenal medulla thought to be a pheochromocytoma, and nodular proliferation of the glial tissue surrounding the ventricular system of the brain. Since obviously the child had multiple tumors of neural origin, the pathologist felt that both neuroblastomas were probably primary. This is the patient mentioned previously whose sibling died at 2 years of age with a poorly differentiated malignant tumor of undetermined type.

There are no specific symptoms and no characteristic manner of onset to distinguish The initial symptoms are these tumors. often vague and tend to occur intermittently, asymptomatic periods intervening. Common early non-specific symptoms are fever, lymphadenopathy, pain, gastrointestinal disturbances, and perhaps locomotor disorders. Accordingly, the initial diagnosis is often infectious mononucleosis, appendicitis, lymphadenitis, osteomyelitis, poliomyelitis, or rheumatic fever. 17 Perhaps the most common initial sign is the accidental finding of a swelling or mass, usually in the abdomen. The presenting complaints in this series are summarized in Table 1.

Lymphadenopathy is not usually an early sign except of tumors arising in the thorax

No. Patients

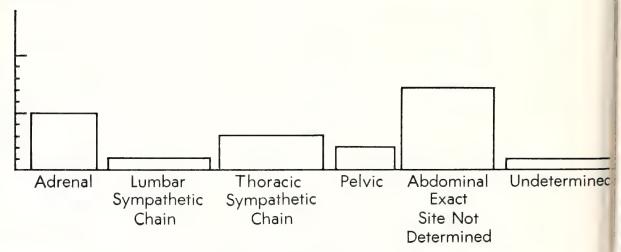


Fig. 2. Site of tumor.

or cervical region. In these cases biopsy of an enlarged cervical or supraclavicular node may lead to an early diagnosis.

Lesions of the head and neck

Symptoms of increased intracranial pressure are usually due to metastatic lesions. Primary intracranial neuroblastomas do occur but are extremely rare. Often the first indication of a neuroblastoma is periorbital ecchymosis or proptosis, since the orbit is frequently the site of a metastasis. These findings in a young child should always bring to mind this diagnosis.

Metastases frequently involve the mandible or maxilla, but not as often as they do the skull and tubular bones. These are often painless lesions with a variable amount of underlying bone destruction. Primary lesions in the nasopharynx and orbit have been reported but are rare.

Masses occurring in the neck are very likely to be confused with infectious lymphadenitis, lymphomas, or cysts. The persistence of a painless progressive growth in the absence of trauma is often the case with a cervical neuroblastoma.

Table I
Frequency of Presenting Complaint in Children
with Neuroblastoma

Complaint	No. Cases
Abdominal mass	5
Fever	3
Respiratory difficulty	2
Scalp nodules	2
Pain in legs	2
Erythema of face	2
Changing bowel habits	1
Failure to thrive	1
Bleeding gums	1
Proptosis	1
"Osteomyelitis"	1
Diarrhea	1
Foul-smelling urine	1
Cough	1
Periorbital swelling	1
Cervical mass	1
Rash	1
Anorexia	1

It has been stated that a persistent cervical mass in a child under one year of age should be especially suspect. Primary neuroblastomas of the cervical sympathetic chain may occur at any level. Horner's syndrome, tracheal deviation, and edema of the

arm from compression of blood vessels and lymphatics are common in cervical tumors. Metastatic lesions tend to appear first in the left supraclavicular (Virchow's) node. Gross¹⁴ felt that primary cervical neuroblastomas have less tendency to metastasize, possibly because they come to the attention of the physician earlier than do tumors in other sites.

Lesions of the chest

Due to the adaptability of the thorax and mediastinum to growing masses, tumors in this area often become quite large before they are discovered. Symptoms of cough, tracheal compression, and edema of the face and neck due to encroachment upon upper mediastinal vessels are almost never found until the disease is far advanced. In one of the cases of a primary mediastinal neuroblastoma in this series, the patient presented with pleural effusion and respiratory distress secondary to tracheal compression.

Neuroblastomas seldom metastasize to the lungs, although pulmonary metastasis may be present in far advanced disseminated disease. This is a helpful point in differentiating them from nephroblastoma (Wilms' tumor), with which they are often confused. Again, Horner's syndrome may occur. Scoliosis is associated with a high percentage of intrathoracic neuroblastomas, commonly concave toward the side of the mass. Pressure deformities of the ribs and vertebrae are also common.

It is worth noting that while neuroblastomas rarely metastasize to the lungs and mediastinal nodes, metastasis to the ribs is common. According to previous reports, calcification, which is commonly present in retroperitoneal neuroblastomas, is rarely found in intrathoracic tumors. Barrett¹⁰ noted that this was not the case in his series, but he did observe that the calcification was seen only in overpenetrated films. Calcification was noted in one mediastinal tumor in this series.

Retroperitoneal lesions

The presenting sign of a retroperitoneal neuroblastoma is almost always a mass, usually felt in the flank or subcostal region.

These masses are often confused with enlarged viscera and may be differentiated only by roentgenogram. The presence of calcification in the mass favors a diagnosis of neuroblastoma. An intravenous pyelogram is often helpful. If a neuroblastoma is present, the collecting system of the kidneys may appear normal, but one kidney is often displaced, sometimes to a considerable extent. Obliteration of the psoas shadow is sometimes observed, and rarely hydrone-phrosis due to ureteral compression may be present.

Pelvic lesions

When neuroblastomas occur primarily in the pelvis, symptoms are usually attributable to bowel or bladder dysfunction. In two cases presented in this series, the tumor was felt on rectal examination when the patient presented with disturbed bowel function. Edema, diminished warmth, and perhaps cyanosis of the lower extremities may occur. Rarely a mass is palpable in the buttock.

Spinal and skeletal lesions

Since neuroblastomas commonly arise from the paraspinal sympathetic chain and ganglia, the tumor may have an intraspinal as well as an extraspinal component. It is obvious that the intraspinal portion will produce cord symptoms. It is wrong to assume that the two portions of these "dumbbell" tumors will grow at the same rate. The cord symptoms may occur prior to, concurrent with, or subsequent to other symptoms. Perhaps the most common cord symptom is motor weakness. Muscle spasm can occur, and in early cases hyperreflexia may be followed by hyporeflexia and areflexia. Pain in the back or legs is a valuable finding in an older child, but it may be difficult to evaluate in the young. The spinal fluid may be xanthochromic, with increased protein. In one case presented here, the first objective evidence of disease was a markedly increased spinal fluid protein level in a child presenting vague, nonspecific symptoms.

In many instances the first indication of disease may be referable to skeletal metastases. As mentioned previously, the skull and tubular bones are particularly prone to be affected. For some unknown reason, flat bones are rarely involved. Roentgenographically, the lesions are small osteolytic defects with irregular margins and minimal periosteal reaction. Productive lesions are not uncommon. The long bones show a tendency for bilaterally symmetrical involvement. These lesions can progress extremely rapidly, destroying a whole bone in a few weeks, but often they are relatively static.

Accessory Diagnostic Aids

Urinalysis

In recent years a new diagnostic test for neuroblastoma has been established. In 1956 Armstrong and his co-workers²⁰ discovered a previously unknown constituent of human urine. One year later they identified it as 3-methoxy-4-hydroxymandelic acid. At the same time they proved that it was a metabolite of norepinephrine. More recently it has been proved that this metabolite, vanillylmandelic acid (VMA), is the chief breakdown product of norepinephrine and that it is excreted largely independently of nutritive factors and thus represents a measure of the turnover of the catecholamines.

It has also been found that a comparable situation exists with regard to pheochromocytoma, the hormonally active tumor of the adrenal medulla. Here, however, VMA excretion not only rises during the hypertensive episodes, but also when the catecholamine levels return to normal. Excretion values are also much higher than is the case with catecholamines; therefore, the measurement of VMA excretion serves as a finer diagnostic tool.

Mason²¹ and his group, in 1957, found increased excretion of pressor amines in an infant with neuroblastoma, and in 1959 Greenberg and Gardner²² reported a case of ganglioneuroma with chronic diarrhea and increased VMA excretion. It now appears that the tumors of ganglion as well as of chromaffin cells may elaborate the pressor amines, their precursors, and/or their metabolites. Although hypertension has been associated with neuroblastoma in a few ca-

es, it is not a common finding. The reason is not yet known. In normal adrenal medullary and autonomic nervous system tissue, epinephrine and norepinephrine are stored in specialized granules which are thought to protect the free amines from enzymatic degradation. Page,23 in studying the biochemistry of neuroblastoma tissue, found that the methoxylated derivatives of norepinephrine were present in concentrations equivalent to those present in pheochromocytoma. However, when he fractioned the neuroblastoma cells, he found much lower concentrations of these derivatives in the fraction containing the granules. This suggested to him that in certain tumors the production of the catecholamines exceeded the capacity of the granules to bind them, and they were therefore rapidly degraded in situ without an opportunity to exert their pharmacologic activity.

There are other possible explanations for the absence of hypertension with neuroblastoma. In pheochromocytoma, usually only epinephrine, norepinephrine, their methoxy analogs, and VMA are excreted in abnormal amounts. The process is orderly, and apparently normal biosynthetic pathways are utilized. In neuroblastoma, however, a much wider spectrum of catecholamine precursors and metabolites appears in the urine. These compounds appear to be handled more or less chaotically. Elevation of virtually every known metabolite of the catecholamines has been found in the urine of some patients with neuroblastoma. There is no consistency, however, in the degree of elevation. In any one patient, the majority may be within the normal range of excretion, with only a few showing marked elevation. This apparently reflects the variability of the individual tumor.

Stickler and Flock,²⁴ in 1962, reviewed the literature on this subject and found at least 50 patients in which determination of urinary catecholamines or their precursors had been made. Of these, 46 had elevated excretion of one or more of the catecholamines or their metabolites. Von Studnitz and his group,²⁵ in measuring a number of these compounds, found that generally norepine-

phrine or VMA was the most consistently as well as the most markedly elevated. It has been postulated that this wide spectrum of metabolites may reflect the use of minor or aberrant biosynthetic pathways, and possibly no compound with pharmacologic activity is ever formed.

Several conclusions of clinical significance can now be drawn. Although the urinary excretion of the pressor amines and their metabolites is usually increased in neuroblastoma, the degree of increase is much less than with pheochromocytoma. The determination of these products in the urine may be of value in the initial diagnosis as well as in following the patient's clinical course. It has consistently been shown that with complete removal or regression of the tumor, the urinary levels of the catecholamines and their metabolites fall rapidly to normal levels. If, however, residual tumor remains, the levels may fall but not to normal levels.

The clinical importance of this fact in evaluating patients is obvious. Voorhees and Gardner²⁶ recently reported a case in which the patient had been treated and was clinically well but continued to excrete abnormally large amounts of dopamine and norepinephrine. Upon surgical exploration residual tumor was found and removed, following which excretion of these compounds immediately fell to normal levels.

The association of chronic diarrhea with these cases is well documented, but its mechanism is as yet unexplained.

Bone marrow examination

Other less helpful accessory clinical measures in the diagnosis of neuroblastoma are bone marrow examination and tissue culture. Marrow examination is routinely done in most institutions, but its value is limited to situations in which malignant cells are found. Rarely, if ever, will the pathologist be able to give an unequivocal diagnosis as to tumor type on the basis of a marrow preparation. Of course the finding of a normal bone marrow does not exclude the diagnosis. If an abdominal tumor is present, marrow examination may be helpful in dif-

ferentiating neuroblastoma and Wilms' tumor, since infiltration of marrow is common in neuroblastoma but has not been reported in Wilms' tumor.

Another value of marrow aspiration is the possibility that disseminated disease may be first detected in marrow aspirates. Delta and Pinkel³¹ report that of 30 children with neuroblastoma, 18 had definite evidence of marrow invasion at the time of admission, and in 8 of these, roentgenograms of the skeleton failed to show evidence of metastasis. All of these children, however, were dead within six months.

Tissue culture

Tissue culture is a refinement that may be helpful in tumors that present difficulty in diagnosis. When biopsy material is cultured in clotted plasma, two distinctive features are noted. First, typical neurites are produced by the cells. Second, there is necrosis of the outer rim of cells, which have an affinity for neutral red when it is applied supravitally. Beck and Howard¹³ feel that a positive diagnosis can be made within 24 hours or less with the use of tissue culture.

Histologic examination

The ultimate in diagnosis in this as in any tumor, however, resides in confirmation by histologic study. Indeed in many cases biopsy of an easily accessible lesion may save valuable time in reaching a definite diagnosis. Scalp nodules and lymph nodes are perhaps the best sites for biopsy when they are involved in tumor spread. This does not eliminate the necessity of locating the primary lesion, however. Whenever surgical exploration is necessary to reach a definitive diagnosis, it is always best for the surgeon to be prepared to remove the tumor as completely as possible at the time a diagnosis is being made.

Differential Diagnosis

Obviously when a disease can produce such a wide spectrum of clinical symptoms as neuroblastomas do on occasion, a multitude of clinical syndromes must be ruled out. The most common of these are infectious processes and other neoplasms. Less commonly metabolic disorders must be differentiated. When a cervical mass is the presenting complaint, an infectious process will be the most likely source of confusion. Neuroblastomas, however, usually present painless swellings unassociated with trauma, and peripheral blood smear will not show the shift to the left characteristic of infectious processes.

When an abdominal mass is noted, Wilms' tumor will certainly be considered. Neuroblastomas are more likely to extend across the midline of the abdomen than are Wilms' tumors. Plain roentgenograms of the chest and abdomen and intravenous pyelograms will be of great help in these cases. Calcification in an abdominal mass is much more characteristic of neuroblastoma. Pyelograms indicate distortion of the calyceal system in a majority of cases of Wilms' tumor but in only one third of the cases of neuroblastoma.10 Metastatic lesions of the lung are suggestive of Wilms' tumor while bony metastases, especially those involving the long bones or skull, suggest neuroblastoma. The ultimate differentiation may well require surgical exploration and histologic study.

When bone changes are the presenting feature, leukemia is the diagnosis most likely to be confused with neuroblastoma, although on occasion Ewing's sarcoma, reticuloendotheliosis, and tuberculosis may be confused. Neuroblastoma characteristically produces bilaterally symmetrical lesions, a solitary bone lesion being the exception. Bony changes in leukemia are usually much less evident, and the skull is much less frequently involved. The soft tissues overlying a bone lesion of leukemia are said never to be involved, while they sometimes are with neuroblastoma.

Histologically a neuroblastoma must be differentiated from lymphosarcoma, rhabdomyosarcoma, Ewing's sarcoma, and reticuloendotheliosis. This may prove extremely difficult in the poorly differentiated tumor.

Treatment

There has been a tendency in the past to consider the treatment of neuroblastoma as

hopeless, and it is certainly true that in most instances the prognosis must be extremely guarded. On the other hand the tendency of this neoplasm to undergo spontaneous regression, however slight, as well as to differentiate into a benign ganglioneuroma, offers some degree of hope in every case, and well documented long-term survival is not rare.

Surgery

As in the case with any malignancy, the optimum treatment is complete surgical excision. Unfortunately, this is often impossible, but long-term remissions and cures have been recorded following partial resection or even biopsy without other treatment. Apparently these result from hemorrhage with consequent necrosis of tumor tissue. Spontaneous hemorrhage into these very vascular tumors is thought to account for significant number of "spontaneous cures," and in some cases has been severe enough to produce hypovolemic shock and death. In addition to surgical procedures, several other therapeutic measures have apparently been associated with spontaneous regressions or differentiation or both. These include radiotherapy, Coley's toxins, nitrogen mustard, folic acid antagonists, and cortisone.

Complete surgical removal of a neuroblastoma in a cervical or other peripheral location is often possible. Likewise a well differentiated ganglioneuroblastoma in the thorax or abdomen may be accessible to surgical removal; but the poorly differentiated tumor is rarely completely removable because of its infiltrative growth and frequency of lymph-node metastases. In spite of this, Dargeon³² feels that an attempt should be made to remove as much as possible of the primary tumor even if known metastases are present. This plan of treatment is supported by several pieces of evidence.

1. Koop and his group³³ found that removal of all or a major portion of a neuro-blastoma, even in the presence of metastases, carried a better survival rate (59%) than

was found when biopsy alone was performed on a tumor considered inoperable (9%).

- 2. Since neuroblastoma may be of multicentric origin and the various loci may have different potentials of malignancy, it is conceivable that removal of the major tumor may greatly improve the child's prognosis should the remaining lesions be more benign.
- 3. If the theory of physiologic reciprocal growth of tumor cells of similar type but in different locations is valid, the removal of any tumor will affect the proliferation of remaining tumors. Certain reported cases of neuroblastoma, as well as other tumors, in which metastases have regressed after removal of the primary lesion seem to support this theory of interdependence.
- 4. If the whole tumor is not resectable, a biopsy may be done and ligation of feeder vessels may be possible. As mentioned previously, any surgical insult to a neuroblastoma apparently increases the likelihood of spontaneous regression.
- 5. In almost every instance the extent of tumor involvement can be determined and delineated by metal clips as an aid to the radiotherapist.

Irradiation

One of the few encouraging aspects of the treatment of neuroblastomas is that the majority of them are radiosensitive. It is currently standard procedure in almost every institution to give radiation therapy to an incompletely removed neuroblastoma. Most authorities also recommend radiation therapy to the tumor bed of an apparently completely excised tumor. In addition, radiotherapy is frequently given to metastatic lesions for palliation. Phillips¹⁷ advocates irradiating skeletal metastases that are destroying large areas of bone or producing pain, but feels that irradiation of small asymptomatic bone lesions is unnecessary since this does not appreciably lengthen survival. If palliative irradiation is given for proptosis, the entire cranium should be included in the field as recurrence is prob-

Table 2 Summary of Eighteen Cases Seen at North Carolina Hospital—1955-1964

			Primary			
No.	Sex	Age	Site	Metastases	Treatment	Result
1.	F	2 yrs 1 mo	Pelvic	Lymph nodes	Sur gery Irradiation	No evidence of disease after 4 yrs
2.	F	9 mos	Adrenal	110405	Surgery	Expired
٥.	-	V 11105	Thoracic		Surgery	during
			Sympathetic			surgery
			Chain			July 5
3.	\mathbf{F}	3 yrs 1 mo	Adrenal	Skeletal	Surgery	Expired 3
	-	0 310 1 1110		Brain	Prednisolone	
				Lung	Cytoxan	diagnosis
4.	M	36 hrs	Adrenal			Expired 1 hr. after admission - Diagnosed at autopsy
5.	M	4 yrs 10 mos	Thoracie	Orbit	Vincristine	Expired 1
-		- 5 - 2 - 1100	Sympathetic	Lymph	Cytoxan	mo. after diagnosis
			Chain	nodes	Irradiation	area area
6.	\mathbf{F}	2 yrs	Abdominal	Lymph	Irradiation	Expired 13
	_	_ v		Nodes		days after
				Skeletal		admission
				Intracranial		
7.	\mathbf{F}	7 mos	Abdominal	Skeletal	Irradiation	Lost to follow-up 11/2
				Liver		mos after diagnosis - disseminated disease
8.	M	9 mos	Abdominal	Skeletal	Surgery	Lost to follow-up
				Testis	Irradiation Cytoxan	2 2/12 yrs. after diagnosis - no evidence of disease
9.	\mathbf{F}	3½ mos	Abdominal	Lymph	Surgery	No evidence of disease
				Nodes		2½ yrs after diagnosis
10.	M	Newborn	Lumbar	-	Surgery	No evidence of disease
			Sympathetic Chain		Irradiation	3 yrs after diagnosis
11.	M	2 yrs 6 mos	Adrenal	Skeletal		Lost to follow-up after
					Cytoxan	8 mos; Disseminated
					Methotrexate	disease
12.	\mathbf{M}	8 yrs 11 mos	Adrenal	Skeletal	Leukocristine	Expired 2
				Liver		mos after
				Lymph nodes		diagnosis
13.	\mathbf{F}	$3\frac{1}{2}$ mos	Abdominal		Surgery	No evidence of disease
1.4	177	F	TT:- 3 - 4 1 1	Clealatal	Irradiation	5 yrs after diagnosis
14.	F	5 mos	Undetermined	Skeletal		Expired 2 yrs
				Lung Liver	Cytoxan Vincoleuko-	10 mos after
				Brain	vincoleuko- blastin	
				Mediastinum	DIASTIII	diagnosis
15		0	Thorogia	Mediastinum Skeletal	Irradiation	Evnirod 2
15.	M	8 mos	Thoracic		Irradiation	-
			sympathetic	Lymph nodes	Vitamin B ₁₂ 6-Mercapto-	
			chain	nodes Liver	purine	diagnosis
1.0	Tr	11/ ****	Dolesia			No evidence of disease
16.	F	$1\frac{1}{2}$ yrs	Pelvic	Lymph nodes	Surgery	6 yrs after diagnosis
17	E	9 venus E	Abdominal		-	
17.	F	8 yrs 5 mos	Abdominal	Lymph	Surgery	Lost to follow-up 3 yrs
				nodes	Irradiation	after diagnosis - disseminated disease
18.	F	3 yrs	Abdominal	Skeletal	Cytoxan Surgery	Lost to follow-up 1

able if only the involved orbit is irradiated.

Although postoperative radiotherapy is generally accepted as the best available therapy for residual neuroblastoma, Koop,³³ in reporting a series of 39 patients of whom 12 had survived for more than 14 months following partial or complete removal of tumor, felt that their survival was unrelated to their radiation therapy. In numerous other reported series the best survival rates occur with a regimen of surgery followed by irradiation.

In evaluating patients for this therapy one must be aware that the therapy itself is not without inherent dangers. The more severe complications in children are radiation nephritis, delayed or arrested bone growth, pulmonary fibrosis, cataracts, cutaneous and thyroid carcinoma, leukemia, and sarcomas of bone or soft tissue.

Chemotherapy

It has usually been the practice in the past to reserve chemotherapy for cases of widely disseminated disease or to give it postoperatively as an adjunct to radiation therapy. Consequently, many of these cases were considered terminal when chemotherapy was A great number of compounds initiated. have been used, but none have proved satisfactory. Coley's toxine, arsenicals, alkylating agents, antimetabolites, urethrane, fluorinated pyrimidines, sex hormones, vitamin B₁₂, Mito-mycin-C, Leukocristine, Streptonigrin, Vincaleukoblastin, Actinomycins, and many others have been used at one time or another in the treatment of neuroblastoma.

Bodian³⁴ has had good results with massive doses of vitamin B₁₂. He reported clinical remissions of 2 to 12 years' duration in 39% of the cases so treated, and temporary remissions in another 10%. Others have found this treatment less successful, and Bennett¹⁵ used it in 26 cases with no success.

Dargeon³² has advocated nitrogen mustard followed by radiotherapy and antimetabolites, but admits that he has no evidence that survival time is affected thereby. Far-

ber³⁵ reported encouraging results with 4aminopteroylaspartic acid ("amino-an-fol") alone or in conjunction with other drugs. In a series of 7 patients receiving Vincristine, James³⁶ reported moderate regression in 2 patients and significant regression permitting complete surgical excision in one. Koop³⁷ also obtained temporary remission in 3 of 6 patients given this drug. He reported good results in one patient given Mitomycin C, but Evans38 used it in 2 cases with no success. Thurman³⁹ employed cyclophosphamide in 24 children with disseminated disease, of whom 19 (79%) responded for periods of from 1 to more than 20 months. Kontras⁴⁰ and Darby⁴¹ also obtained favorable results with cyclophosphamide.

It is apparent that the ideal chemotherapeutic agent is not yet available. Conflicting results and the small number of patients reported, coupled with the fact that many children received chemotherapy along with radiotherapy, makes the evaluation of effectiveness very difficult. Currently it appears that the best results in terms of survival time are obtained from excision followed by radiation therapy and cyclophosphamide.

The treatment of the children in the present series is summarized in Table 2.

Clinical Course

Neuroblastomas are usually first detected clinically by the signs of a neoplastic process. In fatal cases these signs rapidly progress to include osseous invasion - especially of the skull and tubular bones - fever, cachexia, anemia, and purpura. Local infiltration is almost always present and spread occurs by both lymphatic and hematogenous routes. Because of the highly vascular nature of this neoplasm, hemorrhage into the tumor or neighboring structures is common. The bone marrow is frequently invaded, and the anemia and purpura are secondary to marrow disorganization. Skeletal metastases are particularly common except during the first year of life, at which time liver metastases are frequent.

Cervical, thoracic, and pelvic tumors are less prone to metastasize than abdominal tumors, and pelvic tumors may show a relatively low incidence of extension. If untreated, the course of the disease is rapidly fatal, death usually occuring in four to six months from debility, hemorrhage, or intercurrent infection.

Metastases are often present at the time of diagnosis. Wittenborg⁴⁶ found this to be the case in 60% of his patients. Lymph nodes are most frequently involved. Of the bones the femur, humerus, skull, and pelvis are the most common sites. In the limbs, proximal involvement is more common than distal, and the femora are more often affected than the humeri. The dura mater is resistant to the tumor as a rule, and the central nervous system is not often invaded.

Spontaneous regression

Any large series of reported neuroblastomas include some cases in which the disease apparently has been completely arrested. Some of these instances occurred without therapy, while in others the response to therapy was unexpected and could not have been anticipated in the usual course of events.

Two explanations for the regressions have been proposed. Cushing and Wolbach⁴⁷ first described a case of neuroblastoma that was confirmed by biopsy and considered inoperable. The patient was treated with Coley's toxins and years later was re-evaluated. At this time only benign ganglioneuroma was found. Their explanation was that since neuroblastoma is an embryonal tumor, it may undergo differentiation into a more mature cell. This theory is conceivable but lacks confirmation.

It is known that hemorrhage into a neuroblastoma occurs with some frequency and at times can destroy a significant part of a very large tumor. It has been postulated that the hemorrhage and resultant necrosis may destroy either the entire tumor - an unlikely event - or the most malignant part of the mass, leaving only well differentiated cells that then develop into a more benign lesion. It seems quite credible that the unexpected remission which sometimes follows a biopsy may be attributed in part to hem-

orrhage and necrosis, but rather unlikely that this alone accounts for complete remission.

Stewart⁴⁸ reported 3 cases of spontaneous regression of neuroblastoma, but he feels that the most likely explanation is the development of some host resistance factor. In one of his cases he found large numbers of mononuclear inflammatory cells around the tumor on a biopsy specimen. He interprets this as the presence of active resistance on the part of the host and postulates that other cases of spontaneous regression may reflect the development of a sort of immunity on the part of the patient, with the result that tumor cells are actively destroyed. This theory lacks proof and is not widely accepted by workers in this field.

Prognosis

Despite the tendency of neuroblastomas to undergo spontaneous regression, and in the face of the best treatment available, the prognosis remains guarded at best. Up to 1945 there were only two reported cases of long-term survival. In 1951 Beck¹³ reviewed the literature and found a total of 475 cases, 47 of which were reported to have been cured. The duration of follow-up of three cures was not given, however.

Several factors affect prognosis. It is often said that tumors present at birth or occurring during the first year of life are more likely to undergo remission. In his cases, King¹¹ found no correlation between age and survival. Dargeon¹ has suggested that the factor of survival in certain age groups may possibly reflect better opportunity for early diagnosis and not age *per se*.

The site of the primary tumor is of some significance. Primary cervical and pelvic tumors generally have a more favorable prognosis. Two factors may operate here. In these areas symptoms are produced early, and consequently treatment is instituted early. Pelvic tumors are generally thought to have less tendency to metastasize than others. Wittenborg⁴⁶ feels that the site of the primary lesion is not so important as the site of metastases. It is widely accepted

that skeletal metastases are a poor prognostic sign. Goldring,⁴⁹ in 1951, reported the first such case to recover. Conversely, hepatic metastases often disappear completely when a primary retroperitoneal tumor is removed. When the diagnosis is made before metastases have occurred, the survival rate is two to three times higher then when metastases are present at the time of diagnosis.

It is believed that the more differentiated tumors generally favor longer survival. This would be of considerable prognostic import were it not that in many instances mature ganglion cells are located adjacent to poorly differentiated cells in the same tumor. As mentioned previously, hemorrhage into a tumor with resultant destruction of cells also favors prognosis.

At present it is difficult to correlate type of treatment with prognosis except to say that in almost every reported series the best results have been obtained with surgery followed by radiation. The role of chemotherapy in prognosis must await more reports before critical evaluation can be made.

In conclusion one can say that although the outlook for this condition remains poor, it is by no means hopeless. The rare case of spontaneous regression, the good results obtained from surgery and radiation therapy, and the encouraging reports concerning the use of chemotherapeutic agents offer some hope for every child with neuroblastoma.

Summary

The literature on neuroblastomas is reviewed, with special emphasis on diagnosis, treatment, clinical course, and prognosis.

A series of 18 cases seen at North Carolina Baptist Hospital in a ten-year period is reported. An attempt has been made to correlate the findings in this series with information gleaned from the literature.

References available on request

Ventricular Fibrillation Following Cardioversion

Report of a Case

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Direct-current electric shock to the heart (cardioversion) has been found to be a valuable method of therapy for certain disorders of cardiac rhythm. It has been advocated as the treatment of choice in some cases of ventricular tachycardia, particularly for those in which shock or lack of response to usual medical measures is observed.1 Complications from this procedure have been few. Until recently no one had reported ventricular fibrillation as a complication unless the current had been administered in the so-called vulnerable period of the cardiac cycle. This period is said to be at or near the inscription of the T wave.2 Therefore, it was assumed that if proper synchronization were achieved, this arrhythmia would not occur. The case reported here is an example

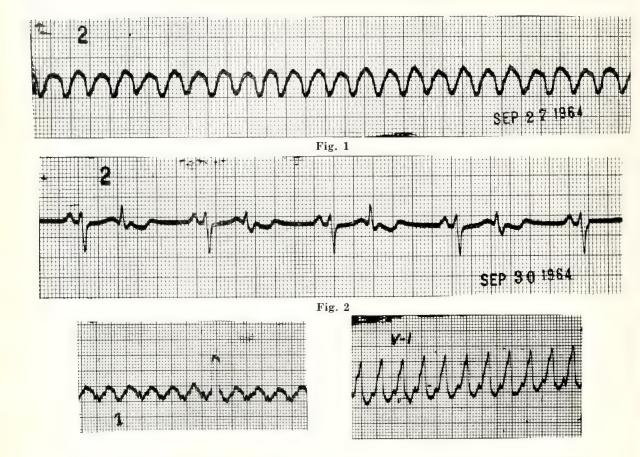
of ventricular fibrillation induced during treatment of ventricular tachycardia complicating a recent myocardial infarction.

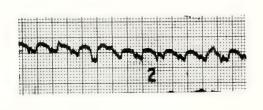
Report of a Case

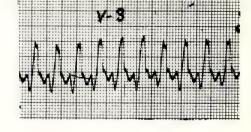
A white man, aged 41, was admitted to the hospital on August 1, 1964, complaining of severe chest pain. He had been in good health prior to the onset of the pain, which began at noon on the day of admission. An electrocardiogram showed the typical pattern of an infarct of the anterior wall of the left ventricle. His skin was greyish-blue and wet with sweat; his pulse was weak and rapid, and his blood pressure was 90/60 mm Hg. His symptoms subsided after about two days, and he was discharged to complete his convalescence at home on August 15.

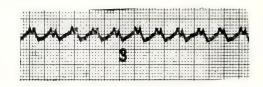
He had no complaints until September 27, 1964, when suddenly, at 9 A.M., while sitting

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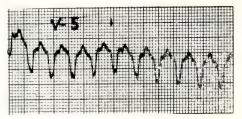


Fig. 3

Fig. 1. First attack of ventricular tachycardia, terminated by drug therapy. Close observation suggests independent atrial activity, manifested by alternation of voltage of the ventricular complexes.

Fig. 2. This record shows bigeminy due to ventricular premature systoles. Other tracings did not show the bigeminal regularity; varying foci of

ventricular premature systoles were apparent in them.

Fig. 3. Leads showing the second episode of ventricular tachycardia on October 6, 1964. The low amplitude of the complexes in the limb leads would not trigger the synchronizing mechanism, but the high deflection of V2-3 produced good synchronized discharge from the capacitor.

on the side of his bed, he became very weak, giddy, and faint. He was re-admitted to the hospital immediately and was found to have a rapid cardiac rate with hypotension. An electrocardiogram (Fig. 1) revealed the presence of paroxysmal ventricular tachycardia. Treatment was initiated with quinidine gluconate given intravenously, followed by levarterenol bitartrate in a 5% dextrose solution. Within a few hours sinus rhythm was re-established. Frequent ventricular premature systoles remained (Fig. 2) despite the oral administration of quinidine and procainamide. He felt weak and did not regain the energy which he possessed before the episode of tachycardia.

In the early morning hours of October 6, 1964, he had a second attack of ventricular tachycardia (Fig. 3). He had received 0.4 gm of quinidine sulfate at 12 noon, 4 P.M. and 8 P.M. the previous day. This rhythm persisted despite intravenous and intramuscular vasopressor agents, none of which raised his blood pressure to normal levels. Since he had not received digitalis, it was decided to administer a therapeutic test with this agent. He was given 1.6 mg lanatoside C intravenously at 5 A.M., and no effect on the ectopic rhythm was observed.

After being anesthetized with intravenous thiopental sodium at 9 A.M., the patient was given a single 200-watt second discharge with electrodes over the precordium and the left axilla. A Corbin-Farnsworth model DSYC synchronized defibrillator capacitor-discharge was used. Preliminary testing of synchronization was difficult because of the small R wave in the standard leads. The capacitor discharges only on signal of an R or S spike of sufficient amplitude. However, when a chest lead was used, accurate synchronization was seen to exist.

Immediately following countershock, the tachycardia stopped abruptly, and ventricular fibrillation was visible on the oscilloscope screen. Unfortunately, a graphic record of the relationship of the shock to the electrocardiographic wave complex and the subsequent ventricular fibrillation was not made. Clinical signs of circulatory arrest appeared. After less than 10 seconds, two

unsynchronized shocks of 200 watt-seconds were given. After the second one, sinus rhythm appeared and was maintained during the remainder of his hospital stay. Premature systoles, observed before the development of tachycardia, were no longer present. The patient was discharged from the hospital October 9, 1964.

Despite a maintenance regimen of quinidine, ventricular premature systoles re-appeared. During the night of December 18 a third episode of paroxysmal ventricular tachycardia occurred, graphically confirmed at 10 o'clock the next morning, with a ventricular rate of 200 a minute. The QRS measured 12 mm, a much greater amplitude than that seen during earlier episodes of tachycardia, and this facilitated synchronization of the shock subsequently given to terminate the attack. After re-admission to the hospital, the patient received a single 100 watt-second shock, under light pentothal anesthesia, that effected immediate reversion to sinus rhythm without the intermediate development of ventricular fibrillation. He left the hospital December 20, 1964.

Despite the administration of quinidine, procainamide, and hydroxyzine pamoate (Vistaril), the extrasystoles persisted, many occurring very near the downward limb of the T wave, and these probably triggered attacks of ventricular tachycardia. Table 1 summarizes the next five attacks and their management.

Since January, 1965, he has had evidence of congestive heart failure, even between attacks. Often he would delay seeking treatment for tachycardia, in the vain hope that the attack would subside spontaneously. At these times dependent edema and dyspnea at rest helped to convince him that medical aid should be obtained. After the shock, which never failed to restore normal rhythm, rapid clinical improvement occurred. On the last two occasions treatment was given on a stretcher in the intensive care unit, without anesthesia, but with electrocardiographic monitoring and anesthetic assistance at hand. After a short rest he returned to his home, cardiac rhythm restored and breathlessness relieved. His last

Table I

Date	Hospitalized	Anesthesia	Intensity of DC Shock
12-26-64	Yes	None	100 watt-seconds
12-31-64	No	Pentothal	100 watt-seconds
1- 4-65	Yes	Pentothal	100 watt-seconds
1-25-65	No	None	100 watt-seconds
2-11-65	No	None	100 watt-seconds

medical program comprised quinidine sulfate 0.4 gm every four hours, procainamide 250 mg four times a day, and hydroxyzine pamoate 50 mg three times a day.

In July, 1965, after an attack of persistent precordial pain, he was again admitted to the hospital. The RT segments in leads 1 and aVL were elevated for a short time, the sedimentation rate was 56 mm/hour, and the serum glutamic oxalacetic transaminase was 115 units. He probably had another small infarct; recovery ensued without complication. There have been no further paroxysms of tachycardia, but he has not been able to return to work because ordinary activity produces undue fatigue and many more extrasystoles.

Discussion

Lown and his colleagues,³ who originally described this method of treatment, stated that ventricular fibrillation or standstill did not occur in any of their patients. Graf and Etkins⁴ reported a case in which ventricular tachycardia occurred following countershock for the treatment of atrial fibrillation in a 56-year-old man with rheumatic heart disease. The tachycardia was terminated by additional shocks.

Willis⁵ described a 53-year-old woman who began to have recurrent atrial fibrillation after aortic valvulotomy. Ventricular fibrillation occurred one minute after treatment and was readily terminated by another shock. The one-minute delay led him to stress the importance of monitoring the patient for a short time after treatment. Killip⁶ stated: "Despite meticulous attention to detail, ventricular fibrillation was produced twice in one patient." He remarked that an artefact of the electrocardiographic baseline appar-

ently set off the current at the wrong place in the cycle. Likewise, Morris and his associates stated: "Ventricular fibrillation was induced in 1 patient coincident with an unexpected capacitor discharge, which fell during the upstroke of the T wave. This event was triggered by an artificial upward displacement of the electrocardiographic baseline due to a sudden movement of the patient."

The patient reported by Ross⁸ had had a myocardial infarction six years before he came in for treatment of an attack of supraventricular tachycardia. His previous medication had consisted of 0.2 mg of digitoxin, 0.8 gm of quinidine, and 0.5 gm of chlorothiazide daily. The patient's condition was serious; vigorous medical treatment for the tachycardia was without avail. Potassium chloride was given because of suspected digitalis intoxication. When this failed to help him, lanatoside C, 1 mg, was given intravenously in divided doses. Following this he was subjected to synchronized DC shocks of increasing intensity. The first 100 watt-second discharge produced ventricular tachycardia which quickly blended into fibrillation. The fifth discharge restored the rhythm to the pretreatment supraventricular tachycardia. He died 40 hours after the onset of the paroxysm of tachycardia; there was neither clinical evidence nor necropsy findings to suggest that the electrotherapy was a factor in his death.

Castellanos, Lemberg, and Fonseco⁹ described an instance of ventricular fibrillation following a DC countershock treatment (75 watt-seconds). Their patient was a 47-year-old man who had ventricular tachycardia complicating atherosclerotic heart disease. Synchronization was thought to have

been accurate, but a test strip electrocardiographic record during the shock indicated that it was delivered 0.15 second after the beginning of QRS. Fibrillation lasted 61/2 seconds and was followed by spontaneous reversion to tachycardia. The rhythm was successfully restored to normal after a second shock of the same intensity placed 0.08 second after the beginning of QRS in lead This report listed 310 treatments of arrhythmia by countershock; besides the single episode of ventricular fibrillation, the authors saw five attacks of ventricular tachycardia occurring in patients treated for other arrythmias. These and other examples of iatrogenic ventricular arhythmias quickly disappeared. They posed no therapeutic problem nor threat to the patient's life.

Jensen and his associates, ¹⁰ in reporting the first 50 patients treated by them with this method for atrial flutter and fibrillation, observed in several patients various abnormalities of rhythm after the shock, generally followed by the spontaneous onset of sinus rhythm. In two patients, ventricular tachycardia and then ventricular fibrillation appeared. In the first case, two subsequent shocks produced a recurrence of the original atrial fibrillation; in the second, the ventricular arrhythmia did not develop until 90 seconds after electroshock therapy. Sinus rhythm was restored by delivery of a subsequent shock.

Gilbert and Cuddy¹¹ found that some patients treated for atrial fibrillation showed evidence of over-digitalization after normal rhythm had been restored by cardioversion. Prior to treatment, when the atria were fibrillating, digitalis toxicity was not suspected, but after treatment, disturbances in rhythm usually due to digitalis were detected. Two of their patients died some hours after reversion with ventricular fibrillation. Even though this condition was diagnosed and treated without delay, permanent restoration of cardiac rhythm could not be achieved. The digitalis effect was manifested in one case by multifocal ventricular beats and in the other by ventricular bigeminy. Other cases in which ventricular fibrillation did not develop also showed signs

of digitalis toxicity after sinus rhythm was produced. This experience led the authors to discontinue digitalis for a few days prior to converting a later group of patients, and in these no digitalis effects were seen in the post-treatment electrocardiogram. It is unlikely that these deaths could be attributed to the cardioversion itself. They were probably the result of advanced cardiac disease, and digitalis may have been a precipitating factor in the pathophysiology of the fatal rhythm.

This patient and some of the others cited received digitalis in some form prior to treatment. Lown¹ remarked that "serious post-reversion arrhythmias can be diminished if digitalis glycosides are stopped for at least 24 hours when digoxin is the drug employed and for 48 hours when longer acting agents are used." Until further information is at hand regarding the cause of this alarming arrhythmia, it is probably wise not to administer shock to persons who have been receiving digitalis.

Cardioversion is a very important technique. In the case presented here, as in many others, it was probably life-saving. Physicians should be aware of its hazards, but should not hesitate to use this method when it is necessary for the correction of an arrhythmia which threatens the patient's life or future well-being.

Summary

An instance of ventricular fibrillation following cardioversion for paroxysmal ventricular tachycardia is reported. Other cases from the literature are reviewed, some of which were associated with the following factors: (1) faulty synchronization of the shock, (2) accidental discharge of the capacitor during a vulnerable period of the cardiac cycle, and (3) excessive digitalization.

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Renal Glycosuria

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This paper is intended as a brief reminder of a benign condition that is important specifically because of its benignancy. diagnosis of renal glycosuria carries with it a favorable prognosis, but a mistaken diagnosis of renal glycosuria masking diabetes mellitus, or contrariwise, a diagnosis of diabetes mellitus in a case of true renal glycosuria may have grave consequences. Therefore, we plead for a more accurate diagnosis of this condition, and in pursuit of this aim present (1) the brief history of a family in which renal glycosuria was diagnosed, and (2) a summary of the important points relating to this disorder.

Illustrative Report

We have under our care a family in which renal glycosuria is manifested in three successive generations. The disorder was recognized first in a 34-year-old white woman who has had known glycosuria since 1958. Her case was once diagnosed as diabetes, treated with oral hypoglycemic agents for a period, and later rediagnosed as renal glycosuria. Since coming under our care the patient has had constant glycosuria, several random blood sugar determinations that were normal, and a normal glucose tolerance test, again demonstrating constant glycosuria.

This patient's mother, aged 75 years, has a normal glucose tolerance, but evidenced glycosuria on all specimens except in the fasting state. One daughter of the original patient, now 4 years old, demonstrated constant glycosuria and has normal glucose tolerance.

erance. All these members of the family are asymptomatic.

The original diagnosis was made on the 34-year-old mother because of glycosuria demonstrated during a pregnancy in 1958.

For editorial comment see page 151

Other diagnoses have resulted from frequent urine sugar tests done on members of the family as a consequence of the original diagnosis. None have any other demonstrable disease, and all urine specimens are free from protein and contain glucose only.

Discussion

Renal glycosuria is an inherited disorder of the kidney, the site of malfunction being the renal tubule. Two types of tubular defects are theorized: one manifesting as reduction in the total maximal capacity for tubular resorption of glucose, with a normal glomerular filtration; the other, as excessive dispersion of nephron activity with a normal total maximal capacity for tubular resorption of glucose.^{1,2} The latter theory is still a subject of discussion and needs further delineation.

The mechanism of handling glucose in the kidney is still obscure, and basic work needs to be done before conditions relating to glucose transport in the kidney can be understood. It is important to note that other tubular functions are normal in this condition, this being a requisite for the diagnosis.³

As stated previously, renal glycosuria is a familial disorder, with the reported incidence ranging from 0.5 to 1 per 1,000 population. The exact incidence depends upon the criteria used for diagnosis, as we will see later.

The diagnosis, in the broadest terms of reference, is based on the finding of glycosuria in the absence of hyperglycemia or evidence of other renal tubular malfunction. Lawrence⁴ proposed as criteria the finding of any glycosuria with normal glucose tolerance, whether there is glucose in the urine at the start of the test or not. The use of these criteria results in a higher incidence of this diagnosis, and will include a higher number of later proven cases of diabetes.

Marble⁵ outlined stricter diagnostic criteria as follows:

- 1. Glycosuria is present without hyperglycemia. This is evident in the glucose tolerance test. The amount of glucose excreted can vary from less than 10 gm to more than 100 gm per 24 hours.
- 2. The degree of glycosuria is largely independent of the diet, but fluctuates somewhat according to the amount of carbohydrate ingested. In general, all urine specimens should contain sugar, regardless of the time collected.
- 3. The levels of blood glucose are influenced only slightly by dietary carbohydrate. The oral glucose test is either normal or slightly "flat."
- 4. The type of sugar excreted is glucose by chemical test. Other meliturias such as fructosuria, pentosuria, galactosuria, etc., must be excluded. This is simply done by the use of glucose-specific testing substances now readily available.
- 5. Carbohydrates are stored and utilized normally. Additionally, other tubular malfunction, such as aminoaciduria in Fanconi's syndrome, must not be present.

By Marble's criteria, only 84 out of 40,000 subjects with melituria (0.21%) were diagnosed as having renal glycosuria at the Joslin Clinic. In contrast, Lawrence, with his criteria, found that 65% of cases of glycosuria fell into this diagnostic category. The striking difference in incidence accord-

ing to the diagnostic criteria used attests to the probable inclusion of a large number of false diagnoses under the more liberal terms.

The importance of accurate diagnosis is to be stressed, since those patients diagnosed by the stricter set of criteria rarely become diabetic later, while under the more liberal terms, subsequent diabetes mellitus is frequent. This error in diagnosis holds potential danger both for the diabetic patient mislabeled as having renal glycosuria and for the patient with renal glycosuria mistakenly diagnosed as diabetic.

Renal glycosuria in itself is a benign disorder, producing ill effects only when carbohydrates are mistakenly withheld or hypoglycemic agents are erroneously used. It is of interest that pregnancy may result in a temporary state of renal glycosuria due to an increase in the filtered load of glucose without an appreciable increase of tubular capacity to reabsorb glucose. This, we repeat, is a temporary condition, coincident with many cases of otherwise normal pregnancy, which after termination of the pregnancy reverts to normal handling of glucose by the kidney.

Summary

Renal glycosuria is to be remembered for its benignancy. It is to be differentiated with care from diabetes, to avert the harmful effects of misguided treatment for either condition. Prognostic implications warrant the use of the strict set of diagnostic criteria outlined above.

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The Medical Examiner System--Experience In Orange County

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It is a fact that the majority of lay people, and all too many physicians, think that the titles "coroner" and "medical examiner" are synonymous; and this may be one of the principal reasons why so little interest is manifested by the populace in adopting the medical examiner system in their counties. But there is a marked difference between the two systems.

Coroner vs. Medical Examiner

The coroner system is an ancient one, dating back to the Roman Conquest. It is a holdover from British law, and is unfortunately a part of the constitutions of many of our states. At the present time, with our advanced forensic medical knowledge, modern police methods, double indemnity insurance, and workman's compensation, the system is completely obsolete, inadequate, and incapable of handling the changing demands of society.

The coroner is a political figure, and as such is elected by the county for terms of from two to six years with the ever-present accompaniment of political pressure. The medical examiner is a physician appointed by the county commissioners to serve, and has no political stigma.

The coroner may be any citizen of the community, chosen without regard to his qualifications and abilities, physical or mental. The medical examiner must be a qualified and practicing physician in his county.

The coroner must carry out legal, judicial, and medical examinations which he is often quite unqualified to perform. His duties are limited, poorly and inadequately defined by law, and he has no protection from legal suit. The medical examiner is an appointed investigative official, who is concerned only with decisions and actions which he is qualified to perform. He has the full pro-

tection of the law, and no suit can be brought against him.

The coroner's duties are actually confined to death due to homicide, or cases of questionable homicide. They are geared to the detection of crime only, and not to the protection of the innocent and the public at large. The medical examiner's duties cover a much wider and comprehensive field. Any unusual, unnatural, or suspicious deaths undergo his scrutiny. He investigates all deaths unattended by physicians, deaths that occur in penal or corrective institutions, and accidental deaths of any kind. Deaths due to questionable infectious diseases and hazardous industrial accidents are also investigated. No person may be cremated without his written consent.

In the United States at the present time there are 16 states which have established statewide medical examiner offices. Seventeen states have municipal examiners appointed in one or more counties. The old system of elected coroners remains in 17 other states. Seventy-five years ago, in 1877, Massachusetts became the first state to adopt the medical examiner system. In 1946 Virginia, our next-door neighbor, adopted a statewide medical examiner system.

North Carolina's County Option System

In North Carolina, after 25 years of dedicated, concentrated, and almost consecrated effort on the part of a few citizens, mainly that of Dr. Wiley Forbus of Duke University, the General Assembly of 1955 adopted a medico-legal examiner's system. A statewide system had failed to pass during the previous two sessions of the legislature, so a compromise was accepted. The Medical Examiner Act of North Carolina adopted at that time is permissive legislation only. The law allows the county commissioners to adopt or reject the system, the county continuing to maintain a cor-

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oner's office. The commissioners appoint a medical examiner, and he in turn can appoint as many assistant medical examiners as he desires and needs. At the present time *eight* counties are working under this system. There is a coroner and medical examiner in each county, the medical examiner doing the investigative work and the coroner maintaining the political title.

During the 1961 session of the legislature, as part of the court reform and with approval by the public in a constitutional amendment, the coroner's office was abolished as a constitutional requirement. Now, any county which desires can abolish the coroner's office simply by exempting itself from the state law. This act very quietly removed the constitutional requirement for a coroner's office.

During the past 1965 legislative session, through the efforts of Representative Zollicoffer of Vance County, a bill [Ch. 639 (hb 590)] was passed to establish the county medical examiner system and abolish the office of coroner in certain counties. At the present time, this is applicable in 15 counties in North Carolina.

Experience in Orange County

Procedures

Orange County commissioners adopted the medical examiner system in 1964. Although doctors in the county had urged it for 15 years, this action may have been precipitated by the various embarrassments resulting from the Rinaldi case, which occurred during Christmas of 1963. The medical examiner's office, with five assistant medical examiners, officially became active during the month of April, 1964.

One examiner, who is in general practice in the northern part of the county, sees most of the cases in this area. The remainder of the cases are seen by the chief examiner and his other four assistants in the Chapel Hill-Carrboro area, where the majority of the cases are concentrated. An on-call schedule for each month is given to the police, the sheriff's department, the hospital, and various undertakers in the county. The chief medical examiner is on first call at all times.

if he is in town or available; each assistant is on second call for a week or so at a time. The Chapel Hill Police Department maintains a 24-hour switchboard, and the majority of the calls, especially those at night, come through the department. Transportation to cases is furnished by the city police or the sheriff's department, depending on circumstances. This makes for prompt, efficient coverage and entrée, as the medical examiner has no power of arrest and no authority to conduct a hearing or inquest.

After his investigation, the medical examiner then sends a full written report of his findings to the district solicitor of the superior court, the coroner, and Dr. Roy Norton, chairman of the committee on postmortem medico-legal examinations in Raleigh. He also sends a copy to the police or sheriff's department of the city or county involved. In the event of a homicide, the coroner is notified immediately. The coroner is also notified if a death is due to an automobile accident, as he is required by motor-vehicle law to report these deaths.

A short monthly report is presented by the medical examiner's office to each of the county commissioners, the district solicitor, the State Public Health Officer in Raleigh, and various interested officials in the community. A detailed yearly report is compiled by the medical examiner. Over the last 12 months, Orange County medical examiners have investigated a total of 99 cases, an average of about 8 cases per month. These reports are not required by law, but are made in scientific interest and curiosity because we have had no previous statistics on deaths in this category.

The medical examiner is paid a fee on a case-by-case basis. Orange County pays 25 dollars per case. The various medical examiners are given a telephone credit card by the county. Any other incidental expenses are turned over to the county commissioners at the end of the month.

Results

Deaths by natural causes (43 cases) lead the list, followed by accidental deaths (42 cases). The accidental deaths are higher in proportion owing to the number of patients referred to N. C. Memorial Hospital from the surrounding counties. Homicide (6 cases) and suicide (6 cases) are usually equal proportionately in number. Crib deaths and abortions are in the minority.

The autopsies are performed by the pathology department of the North Carolina Memorial Hospital. Theoretically, the mortality committee appoints a district pathologist; however, this has never been done. Consequently, the medical examiner, with the consent of the chairman of the medico-legal committee, adopted the following procedure: If the decedent was a patient in the hospital or has a hospital number with recent hospitalization pertinent to the death, and if the family grants permission for autopsy, it is performed as a hospital service. Otherwise, if the medical examiner orders the autopsy for medico-legal reasons, the pathology department is paid a fee of 150 dollars for a complete study. This fee is paid by the county in which the decedent was a legal resident. The medical examiner may order a postmortem study, if he feels it is advisable and in the public interest. He has the full protection of the law.

Thirty-eight autopsies were performed during the first year of our office—one per ten cases. Twenty-seven were with family permission, and eleven were ordered by the medical examiner. This results in one autopsy per ten cases. Theoretically, the percentage

of medico-legal autopsies should be one in eight cases. (In Guilford County, in 1963, there were 406 cases examined, with 34 autopsies—which is about one in twelve cases.) Six of the medico-legal autopsies were performed on residents of counties other than Orange.

Summary and Conclusion

This is a short resumé of the medical examiner system as it has been carried out in Orange County over the last 12 months. The cost to the county in 1964 was about \$3,500.00.

The duties of the chief medical examiner were not confining, nor did they interfere greatly with his routine practice of surgery. The experience has been interesting, instructive, and informative. We have a feeling of satisfaction in having contributed what we think has been a valuable service to the county.

The law enforcement officers appreciate the assistance given by the medical examiner, and, I believe, the county commissioners feel that it is worth the investment. All unusual, unnatural, and suspicious deaths, including homicides, suicides, and accidental deaths, were examined. All natural deaths, deaths in penal institutions, and crib deaths or abortions were investigated. There is a little of the Dick Tracy in all of us, and the chief medical examiner is no exception.

What a dreadful inheritance is the gout, the scurvy, or the king's evil to transmit to our offspring! How happy had he been born a beggar rather than to inherit his father's fortunes at the expense of inheriting his diseases!—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 27.

Islamic-Persian Medical Education

A Survey from Jundi-Shapur to Cairo

GEORGE PODGORNY, M.D. WINSTON-SALEM

I lay sick, but you came to me at once, Symmachus, accompanied by a hundred students. A hundred hands chilled by the north wind felt me. I had no fever before, Symmachus, now I have.

Martial's epigram from First Century Rome

The practice and the teaching of medicine have always gone hand in hand, although much more attention has been given to the history of practice than of teaching. What information exists in Western tongues about early medical teaching deals largely with Greek, Roman, and European practices. The small amount of information about medical teaching during the long period when Islam preserved the heritage of Greece and Rome is brief, sometimes inaccurate, and scattered through many publications, often of small circulation. This paper deals with medical teaching and learning immediately before and during the "Golden Age of Islam," and is based upon sources in Arabic and Persian.

The medical schools of Islam will be considered, first by focusing attention on the great school at Jundi-Shapur, the earliest full-scale Persian school and the model for all the later Islamic schools. From this beginning the account will continue through one of the last great schools, that at the Qalaun Hospital in Cairo. These two schools embody the elements of medical education during the years covered by this paper. In addition to the intrinsic interest these schools hold for Islam, their influence on later European medical education was great, as illustrated by the almost complete dependence of the medical school of Salerno upon Islamic sources for its origin.

The First Medical Schools

The earliest mode of transmission of medical knowledge, and therefore of medical

education, was speech and, of course, observation. Next came the written word and the early era of book learning. The earliest teaching probably took place at home, on hunting trips, and on the battle field.

Egypt, Greece, and Rome

The earliest "medical schools" apparently were the temple schools of ancient "Egypt."

There priests taught medicine and surgery as well as theology and sorcery. In ancient Greece also, medical instruction was given in the temple. Out of one such temple school grew the School of Cos, where Hippocrates lectured.

The next, and some think a concomitant. step was the establishment of universities where students were prepared for various professions. Possibly one of the earliest was the University of Alexandria, where such scholars as Euclid, Archimedes, and Hipparchus taught. Attached to the university were sleeping quarters, a museum, and a library which in 48 B.C. numbered 700,000 volumes. This university had a well organized medical school. Its founder was Alexander of Macedonia, and the year 323 B.C. is considered as the year of foundation. The school reached its height in the period of Ptolemy II (285-246 B.C.). Classical medical texts such as Hippocrates' Aphorisms were read aloud; then the teacher would add his own exposition.3 The professors arranged suitable selections of works and expounded on them. Preoccupation with minutiae was overwhelming.

A somewhat different approach was used in Greece, where personal supervision was the main feature. Instruction often was a family affair. Hippocrates introduced direct

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observation into the medical curriculum.

In Rome, medical knowledge was imparted in various so-called societies and "colleges." These finally were combined during the reign of Augustus (circa 14 A.D.). Buildings were erected on the Esquiline Hill, and the Schola Medicorum was officially inaugurated during the reign of Vespasian (70-79 A.D. At that time professors were paid from public funds.

The Far East

Japan, China, and India also had more or less formal medical training early in history. Charaka, the famous Indian physician, considered the three best ways of acquiring medical knowledge to be: (1) the study of medical writings, (2) personal instruction, and (3) association with other physicians.⁵ This concept could very easily stand up to present standards of medical education.

The Persian School at Edessa

Before discussing the school in Jundi-Shapur, mention should be made of an earlier similar venture.

In 363 A.D. the Roman Emperor Julian was killed and his army defeated while fighting the Persians under Shapur II. Julian's successor, Jovian, made a rather ignominious treaty with Shapur in which the city Nisibis was surrendered to Persia. This resulted in the migration of a number of learned Christians from Nisibis to Edessa. This group organized the so-called Persian School of Edessa.

A hospital was built in conjunction with the medical school and the study of medicine progressed rapidly.⁷ Teaching was multilingual, being conducted in Persian, Aramaic, Hebrew, and Greek.

(Fairly recently a medical school was established in Ahwaz, one of the centers of the petroleum industry in Iran, and was given the name of Jundi-Shapur. To most foreigners as well as many Iranians, the name was a puzzle; however it is only the revival of a once highly respected name in medical education. Today about 60 miles north of Ahwaz stands the small village of Shah-Abad, where weary and barefooted peasants till land that once was the seat

of learning. For this is all that remains of the once magnificent metropolis of Jundi-Shapur whose name was bestowed on the school of modern Ahwaz.)

Close to Susa, the ancient capitol of Persia, was another city called, in Pahlavi, Genta Shapitra (the Beautiful Garden).10 dowsi, in his monumental work Shahnameh (The Book of Kings), gives details about this city.11 Apparently it was rather stagnant up to the time of Shapur I, the second king of the Sassanid dynasty. In 260 A.D. Shapur I defeated the Roman Emperor Valerian, and at the same time sacked the city of Antioch. Not being satisfied with acquiring a new city, he reestablished and rebuilt Shapitra and renamed it Vehaz-Andev-i-Shapur, which in Pahlavi means, "Shapur is better than Antioch." The old and the new names were pronounced similarly, and finally the name Gondi Shapur emerged and was retained. Later, however, the Arabic equivalent, Jundi-Shapur, began to be used, and persists today.

This city grew rapidly with the new impetus that was given it, and soon became a prosperous metropolis where many great events took place. Among them should be mentioned the only instance known to us of a coronation before birth, when Shapur II (360-379 A.D.) was crowned in utero.¹² This truly great monarch is credited with conceiving the idea and establishing the nucleus of the University of Jundi-Shapur in the latter part of the fourth century.

Mention has already been made of the university and medical school at Edessa, founded by learned Christians who escaped after the fall of Nisibis to Shapur II. About the time this school was founded there was born, near Mount Taurus, an Assyrian named Nestorius. Educated as a priest, he was later (428 A.D.) made Patriarch of Constantinople. Very early he came into conflict with the Orthodox church fathers because of his heretical teaching and preaching. His denial of the complete mergence of the divine and human natures in the person of Christ, and especially his assertion that Mary the Mother of Christ should not

be called the Mother of God, brought him to trial. In 431 he was deposed at the Council of Ephesus and he and his adherents in the Assyrian Church were excommunicated. From that time on his followers were called Nestorians and have since been organized as the Eastern Syrian or Nestorian Church. This church controversy is now uninteresting in itself, but it had a profound effect on the history of medical education.

The Nestorians were largely concentrated in upper Mesopotamia in Edessa and east of the Tigris in Adiabene. The School of Edessa became the center of their teaching. Meanwhile Nestorius retired to a quiet monastery near Antioch, but was finally banished by the Byzantine emperor to the Great Oasis of Upper Egypt, where he died in anonymity.

The troubles of the Nestorians were not ended, however. By 488 the religious controversy flared up anew. Bishop Cyrus of Alexandria persuaded Emperor Zeno to abolish the School of Edessa. This was done in 489 and the teachers and pupils were expelled from Edessa, bringing to an end that great center of culture. Paradoxically, on the site of the school a new Orthodox church was erected and given the name of Our Lady, Mother of God.

Influence of the Nestorians

The banishment of the Nestorians from Edessa had several interesting results. The zealots became missionaries and traveled far and wide. Others of the teachers and students turned to what they considered a more profitable intellectual and possibly financial activity; namely, the study and practice of medicine. Sarton considers this "irritability" of the theologians a centrifugal force.⁶

Following the closing of the School in Edessa many of the theologians, under the leadership of Bar Soma, the deposed Chancellor, returned to Nisibis, from whence the founders of the school had originally come, and established a new school there. Other teachers accepted the asylum offered them by Sassanid King Kobad and migrated to Jundi-Shapur. The latter brought with

them Syriac translations of Greek medical works of Hippocrates and Galen by Sergius of Ra's-al-Ain and the earliest Syriac translations of Aristotle by Probos.⁶

It is my opinion that because of their status as heretics, the Nestorians had been barred from political activity, from many business pursuits, and probably from landholding as well. They consequently turned their energies to the cultivation of learning and acquired wide knowledge not only in theology but also in philosophy and the natural sciences. In addition, the rational and humanistic bent of their religion perhaps predisposed them to literary and scientific activities.

The knowledge that the Nestorians brought with them into exile was fundamentally Greek. At that time Greek was the *lingua franca* of the eastern shore of the Mediterranean, and scientific knowledge was based on familiarity with ancient Greek writings. It was fortunate for the Nestorians as well as for the preservation of Greek medical science that their arrival in Persia coincided with the reigns of enlightened monarchs who respected learning.

The Medical School of Jundi-Shapur

By the time Nushirwan became king (530), the university and medical school of Jundi-Shapur were flourishing. He gave the university the greatest impetus by creating an atmosphere of intellectual freedom and of rewards for excellence. Furthermore, he enhanced the prestige of the institution by welcoming to it the Greek neo-Platonists from the School of Athens when it was closed in 539.7

By the end of Nushirwan's reign in 578, Jundi-Shapur had become the greatest intellectual center of the East and a renowned clearing house for philosophic and scientific ideas. Christian, Greek, Hindu, Jewish, Persian, and Syrian medical knowledge was being constantly exchanged and compared.

Nushirwan patronized the translation of Plato and Aristotle into Persian, and this enthusiasm for translating invigorated the ever active school of translators of Jundi-Shapur.¹⁴ Nestorians, owing to their linguistic capability, made particularly good translators.

Teaching and the exchange of information were done largely in Arabic, which was fast becoming the scientific language of the area. Nushirwan, however, urged the translation of various foreign works into Pahlavi. During his reign Pahlavi literature reached its zenith. The works of Plato and Aristotle were translated, and the historical annals of Persia were compiled, to be used by Firdowsi, four centuries later, as the source of the greatest Persian epic, Shahnameh.

Little is known of the exact nature of the organization and facilities of the university and medical school in Jundi-Shapur. However, from scattered fragments of information derived from various works, and particularly Ibn Abi Usaybia's *Uyun-al-Abna fi Tabaqat-al-Atibba*, the following picture emerges.¹⁵

The physical plant apparently consisted of numerous rather small buildings surrounded by formal gardens, where the warm, dry climate allowed out-of-doors meetings and discussions during most of the year.

Organization

The university can be divided into three major divisions—the first being the school of theology, philosophy, and metaphysics. Here various religious, philosophical, and literary subjects were taught. Apparently in later years an observatory was built where mathematical sciences were separated from the first division and taught in conjunction with astronomy.

The second division could be called the Institute of Translation, and served as a model for later similar ventures. Here, in a well-designed, well-lighted building worked the translators. The "institute' was further subdivided on the basis of fields of study and of language. In each large room a master translator, often himself an authority in the field, presided over the translation of several books at a time. He was surrounded by numerous younger and lesser translators, students, and scribes, who often served as sections of a human encyclopedia. In the dark, dry vaults of the basements

were kept the original manuscripts and their translations. Indeed the wealth of ancient documents at Jundi-Shapur makes the contemporary resources at Monte Casino seem pitifully small.

The third division was primarily a medical school where the basic sciences were probably taught. It seems that medical students spent only a year or less in this section. Many of the students were fellows and physicians doing research or practice teaching while learning. It must be said that most of them came from other schools and already had the generally available pre-

liminary training of that time.

The Bimaristan

Opposite the Great School was built the famous hospital, the Bimaristan, a Persian name used subsequently for all the great hospitals in Baghdad, Damascus, and Cairo, which the Arabs copied from this model in Jundi-Shapur. In this hospital not only were patients attended by the best physicians, but also most of the teaching by the medical faculty was done.

After preparation in the basic sciences students were assigned in groups, on a rotating basis, to well known physicians and surgeons at the Bimaristan. There they followed their preceptor on his rounds, observed his work, listened to his lectures, and engaged in disputations among themselves. Thus they observed the triple methods of modern medical education — namely, book learning, observation of a master's diagnosis and treatment, and association with colleagues.

At the Bimaristan, the teaching hospital was organized into inpatient and outpatient services, and further, into departments of medicine, surgery, orthopedics, and ophthalmology. A pharmacy, kitchen, and medicinal herb garden completed the layout.

Faculty distinctions

The director of the hospital, who was also the dean of the medical school, was always the most outstanding physician of his day. He was assisted by two deputies, one appointed by the Nestorians themselves and the other by the government. The faculty, despite being basically Hippocratically and Galenically oriented, tolerantly allowed their Persian, Hindu, and Jewish colleagues to follow their own methods. This made for tremendous intellectual freedom and breadth of subject matter. The student body was also very international in character. ¹⁶

Among the many important contributions of the instructors at this school was the first serious attempt at classification and systematization of medical knowledge. This served also as an impetus for later achievements of Ibn Sina and Rhazi.

Sabur ibn Saber, the dean of the school, published, in 869, the first known pharmacopeia. Another professor wrote 22 volumes of an antidotary (*Aqrabadin*) in which he discussed every known poison, the diagnosis of the intoxication, and the treatment.¹²

Among other distinctions of the medical school at Jundi-Shapur was the first recorded medical convention, the forerunner of such contemporary meetings as the giant A.M.A. assemblies.

In the year 551 all the physicians of Jundi-Shapur convened by the Imperial decree of Nushirwan to discuss diversified scientific subjects. Their debates were recorded and many physicians of distinction from all over the Eastern world attended. The meetings were presided over by Jibrail Dorostbad, the royal physician, assisted by Safistai and Yohanna, famous physicians and faculty members of Jundi-Shapur.

The medical school of Jundi-Shapur appears to have been the first to require its students to stand licensure examinations. This requirement was later revived in Islamic medical practice.

Until the Arabs built their first hospital in Damascus (706 or 707) and for a long time thereafter, the Jundi-Shapur school was the Padua of the East.

Ahmad Issa Bey, in his work on the Bimaristans, quotes Ibn Ahmad-al-Andahoussi, who wrote in the latter half of the eleventh century as follows:

> The Moslems had no hospitals of their own until the reign of the sixth Omayyad caliph Al Walid-ibn-Abdul who organized the first

Moslem Bimaristan in Damascus. Before this period the Arabs went to Persia for their training in medicine, which they practiced on their return to their native land. Harith ibn Khalada and his son, Nadr, physicians to the prophet Abu Bakr obtained their education in Jundi-Shapur.*

The Arabian Conquests

The medical school at Jundi-Shapur was at the height of its fame and glory in the year 636 when its tranquility was disturbed by the appearance of the Arabian army at its gates. After the battle in Nihawand in 642 all of Persia was subdued by the Arabs, who were sweeping all before them in that remarkable conquest which did not cease until all the lands from the banks of the Ganges to the Pillars of Hercules bowed to Islam.

Though devoid of refined cultural interests, the Arabs were a utilitarian people and tolerated well the Christian-Persian school at Jundi-Shapur, which continued to uphold the finest medical traditions, little affected by the Arabian conquests.

And then slowly the Arabs began slowing down and their ruling class discovered the pleasures and leisure of cultural pursuits.

The caliphs of the Omayyad dynasty began to free themselves of their narrow-minded fanaticism and, with the seat of government transferred from Mecca to Damascus, the Commanders of the Faithful became more worldly. The Omayyads, early in the eighth century, sponsored the earliest known translation of Greek medical works into Arabic. Nasarjawaih, a Jewish physician, translated the *Pandectae Medicae*.

About the same time, the first Moslem hospital was founded in Damascus. I have not found any evidence that much training was carried out at this hospital. Nevertheless it was here that, to prevent the transmission of disease, lepers were first isolated from other patients.¹⁷

The last Omayyad caliph, Marwan II, was defeated in 750, and in the same year Abu-al 'Abbas established the Abbasid caliphate. This was the hey-day of persophiles and of

^{*}Author's translation.

resurgence of refinement and culture. After the death of Abu-al 'Abbas in 754, and until 775, his half brother, Abu Ja'far, ruled as the second Abbasid caliph. He assumed the title of Al-Mansur (the victorious one), and is known in history by this name.

Al-Mansur was the founder of Baghdad, which he raised from an insignificant village to a renowned metropolis and capitol of the caliphate. He was well aware of the great seat of learning in Jundi-Shapur; therefore about 765 he summoned to Baghdad the dean of the school, Jurjis-ibn Bukht Yishu, whose last name means "Jesus hath delivered."15 He was made personal physician to the caliph and also put in charge of the work of translating medical texts into He was responsible for advising Arabic. the caliph to build the first hospital in Baghdad, which became known as the Old Hos-This hospital remained the chief teaching institution for the next two centuries. Here great physicians from Bukht Yishu to Rhazi lived, practiced, and lectured.

The fifth of the Abbasid caliphs was certainly the greatest of them all—the famous Harun-al-Rashid, who became the ruler of his vast empire in 786. He immediately recalled to Baghdad the aforementioned Jurjis-ibn Bukht Yishu, made him royal surgeon, and ordered him to build another

hospital. This was done in the same year and became known as Bimaristan al-Rashid.¹⁸

The Twilight of Jundi-Shapur

Jurjis and his son both finished their days in Baghdad, and with the beginning of the ninth century very little is to be found about the medical school of Jundi-Shapur. Apparently as the chief leaders moved away to the newer metropolis, some of their students followed, and that great school faded away.

Thus suddenly came to an end a great ancient medical center. As rapidly as it had risen to fame, it plunged into oblivion. The school's faculty and alumni carried medical education as well as the art of translation, into all parts of the Islamic world, thus passing along the torch of knowledge and the spirit of inquiry. In the words of Upham Pope:

Here (in Jundi-Shapur) medical studies took on a genuine scientific character which made the school the fostering parent of an immense development that for six centuries constituted one of the most brilliant chapters in the long and uneven story of man's efforts to master his world for the sake of human values. The ninth and tenth centuries stand out in the history of medicine as an age of humanitarianism and beneficience and for this Persia deserves the chief credit. 19

To be continued

To make a show of learning is easier than to write plain sense, especially in a science, which has been kept at such a distance from common observation. It would, however, be no difficult matter to prove that everything valuable in the practical part of medicine is within the reach of common abilities.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 14.

James Parks Rousseau, M.D. -- 1895-1965

A Personal Reminiscence and Appreciation

FRED H. GARVEY, M.D. WINSTON-SALEM

Dr. James Parks Rousseau of Winston-Salem, widely known and loved radiologist, died on September 29, 1965, after several years of declining health. He retired in 1963 because of ill health, but had been seriously ill only three weeks.

Dr. Rousseau, one of the real pioneers in radiology, introduced many of the modern techniques to North Carolina. Much of the physical suffering he endured in his last years was attributable to his use of radiology, without regard to his own welfare, in the treatment of disease. His retirement and death was a great loss to the city of Winston-Salem and to North Carolina.

Dr. Rousseau was born in Wilkesboro on August 23, 1896. He received his B.S. degree in medicine at the University of North Carolina in 1916 and his M.D. degree from the University of Maryland in 1918. served as a lieutenant in the Medical Corps of the U.S. Navy during World War I. After the war he went to New York City and took postgraduate training in radiology at Bellevue Hospital, at Memorial Hospital for the Treatment of Cancer and Allied Diseases, and at New York Postgraduate Hospital. He also studied at Johns Hopkins Hospital in Baltimore. He came to Winston-Salem in 1919 and engaged in the private practice of radiology until 1941.

When the Bowman Gray School of Medicine was established in Winston-Salem in 1941, Dr. Rousseau became professor of radiology and also director of the Department of Radiology of North Carolina Baptist Hospital, remaining in those positions until 1950, when he became emeritus professor of clinical radiology at the medical school and resumed private practice.

During his active years he held numerous offices in medical associations. He was past president of the Forsyth-Stokes Medical Society, past president of the Radiological Society of North Carolina, and also vice president, in 1956, of the American College of Radiology, of which he was a fellow. In 1955 he was elected president of the Medical Society of the State of North Carolina for a one-year term. He served on the Board of Directors of the Winston-Salem Chamber of Commerce in 1955-1956, and was a member of the Forsyth County Board of Health in 1959-1962. He was presented a Distinguished Service Award in 1952 by the Alumni Association of the University of North Carolina School of Medicine.

In the field of community service, Dr. Rousseau was the prime mover in the establishment of the Forsyth Home for the Aged, which was incorporated in April, 1961. He was one of the directors of this organization and remained so until September, 1962, when he retired because of ill health. In appreciation for Dr. Rousseau's past service, particularly in getting the home started, the board made him an emeritus member of that body. In this capacity he was consulted on many occasions before his death.

To write a proper memorial to James Parks Rousseau, one of North Carolina's most beloved physicians, is no small task. His extraordinary energy and accomplishments make a detailed record impossible within present limitations of time and space. Nevertheless, having been chosen for this task because of my long and intimate relationship with "Jake" (as he was always called by his friends), I hope to recall the highlights of his medical career, mentioning his contributions to medical progress as well as to the humanities as he practiced in his community.

Jake had more friends in the medical profession, in my opinion, than any other physician in Forsyth County. This statement probably could be extended to include all of North Carolina. He made it a point to wel-

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come all newcomers to the medical and paramedical professions, and never failed to aid and encourage them in their endeavors. This personal interest, coupled with his winsome personality and other fine attributes, endeared him to all local practitioners and formed the basis of a lasting bond of affection.

In addition to his devotion to his family and community, Jake had two loyalties: One was his passionate interest in the progress of radiology; the other was his intense belief in organized medicine, both state and national. In pursuit of the latter, his activities covered 15 years (from 1945 to 1960) of an intense dedication involving great sacrifice of time and money. His self-effacement and humility prevented full recognition of the amount of time and energy devoted to the development of better medicine in North Carolina.

In this cause he was a crusader, urging greater attention to our obligation as an organized profession to create and maintain the proper image of physicians. He continually used his influence as a watchdog against the perpetual encroachment of the federal government in its efforts to establish a socialistic type of medicine, and strived to maintain the personal equation on which the physician-patient relationship has always rested.

To my knowledge, Dr. Rousseau, in his quiet and unassuming manner, interested many younger man in state medical affairs, persuading them to serve in various capacities when they were inclined to leave such business to aspirers to political fame. Physicians have told me that their interest in public medical affairs was aroused when Dr. Rousseau's encouragement and persuasiveness convinced them of their importance.

Jake's activities along this line were never for self-aggrandizement, but instead were the result of his belief in the organization of the profession as a means of bettering medical care of the sick and as a safeguard against encroachments on what he considered to be the best system of medical care yet devised. His personal interest and devotion to organized medicine in North Carolina became official in 1945 when he became a member of the Advisory Committee to the Industrial Commission. He next became chairman of the Committee on Professional and Hospital Relations. He was then elected to the Board of Medical Examiners and also to the Committee on Prepaid Medical Insurance. In both of these capacities he gave a good account of his abilities. These are only a few of 15 committees on which he served between 1945 and 1960, when only failing health prevented further participation.

In 1955 he was elected president-elect of the Medical Society of the State of North Carolina, and the following year served as president. During this year he devoted most of his time to the affairs of the office, at the sacrifice of considerable income from private practice. Throughout his administration he kept in close contact with his committees, and his interest and inspiration resulted in a great year for organized medicine, not only in North Carolina proper, but in its relation to national medical affairs. North Carolina's part in the general crusade against socialistic legislation in Washington was unusually active during his regime, and he appeared before congressional committees on a number of occasions.

As stated before, Dr. Rousseau was the first professor of radiology and chairman of the department of the Bowman Gray School of Medicine. As with most of us who were in private practice, he had no previous academic experience. In a short time, with his excellent background in radiology, his initiative, and his tireless energy, he developed one of the best departments in the medical school. His residency program was quickly set up and soon became a credit to the institution. From the inception of this program in 1941 until retirement from the professorship in 1950, he trained 12 residents who are now in practice. All were devoted to him.

Dr. Rousseau never confined his energy and talents exclusively to medicine. He found time for many community affairs as well as for recreation in the form of golf and fishing. His versatility was evidenced by his ability to excel in both these pastimes. He was an inveterate bass fisherman, but also loved salt-water and mountain trout angling. In the latter, his proficiency was the envy of his fellow contenders, many of whom professed to be expert with the artificial trout fly. His golf game was much better than that of the average professional man.

During his college days he was an excellent baseball player on the University of North Carolina team. He very well could have gone into professional baseball had it not been for his dedication to medicine.

Jake was a Christian physician who consistently lived according to his beliefs. Church worship and prayer were always important to him, and this influence was manifested in his home life as well as his social and medical activities.

The passing of J. P. Rousseau was a great loss to his family, to medical science, to the community, and to his many friends who loved him. Personally, I never had a greater friend than Jake. His sterling qualities as a physician and his modest and ever honest approach to ethical and moral matters were always an inspiration to me. Many pleasant hours of playing golf and fishing for bass will ever be to me the source of cherished memories of his charming personality and his penchant for fair play.

The close affinity that existed between us was perhaps best symbolized by two important occasions. In 1955, when Dr. Rousseau was installed as president of the State Medical Society, he chose me as his toastmaster for the occasion. This was a high personal honor to me. In 1960, when I was honored at a banquet by the 18 residents I had trained, Dr. Rousseau was my toastmaster. I was honored, not only by his kind remarks, but by his gracious consent to serve on this occasion.

Dr. Rousseau, with his charming personality and warm and humble attitude toward other people, has touched many lives both within and without the medical profession. His death is mourned by all who knew him.

FRED K. GARVEY, M.D.

Report on Trauma

TENSION PNEUMOTHORAX

To diagnose and effectively treat traumatic tension pneumothorax, it is necessary to understand the pathologic physiology of the lesion. Traumatic tension pneumothorax usually results from a fractured rib tearing or puncturing the lung. Air escapes from the lung when the pressure in the pleural space is negative or during inspiration, and during expiration the laceration is closed so that no air can escape. each inspiration an increasing amount of air escapes from the lung into the pleural cavity and is trapped, steadily diminishing the amount of space within the chest for expanded lung. For this reason, the patient tends to assume an ever-increasing position of inspiration, much as does a patient with emphysema who is unable to empty adequately his lungs.

Thus a patient with tension pneumothorax arrives in acute respiratory distress, with a chest that appears to be overexpanded and with shallow rapid respirations. He is usually restless and may even be combative. For a broken rib to tear the lung it must also tear the parietal pleura, so that there is usually evidence of subcutaneous emphysema as manifest by crepitation. This emphysema may be small in amount or quite massive, depending on the size and location of the tear in the parietal pleura. If the patient is conscious and can complain of pain, the localization of a fracture by palpation and any subcutaneous emphysema should in themselves lead to the diagnosis. Chest x-ray, while helpful, is not necessary. If it is decided upon it is important that the exposure be made with the patient in the upright position, after ascertaining that there is no spinal fracture which might be complicated by such movement. If the film is taken in the supine position, the air, fluid and lung will distribute themselves one on top of another so that it may be im-

Reprinted by request.

Third in a series of articles submitted by the Committee on Trauma, North Carolina Chapter of the American College of Surgeons.

possible to determine whether a pneumothorax is present or not. If the patient is sitting up or, if necessary, placed in the lateral decubitus position and the film shot across the table, the air-fluid levels will be immediately identified.

If a patient is in acute distress upon arrival and there is pain in the chest and any evidence of fractured rib plus subcutaneous emphysema, a needle should be placed in the chest in the second anterior interspace and air aspirated without x-ray examination. This will lead to immediate relief of the respiratory distress. If this is the case, water-seal drainage should be instituted immediately. This can be done quite simply by pushing a hemostat or a Kelly clamp into the chest through a small incision in the skin, and then advancing a catheter through the wound tract (fig. 1).

The catheter should be large in size, preferably 26 to 28 French. The ideal place for inserting it is in the second anterior interspace, because there are unlikely to be any adhesions between the lung and the chest wall in this position, and also because the catheter is not likely to get any blood in it and so become occluded with clots. A piece of tubing can then be attached to the catheter and the same tubing placed in a jar under about 2 cm of water. It should be taped in place and clearly marked so that no one will attempt to dump the water out and thus destroy the water seal.

The principle involved in the foregoing procedure is that air can escape by bubbling out through the water, but in order for the

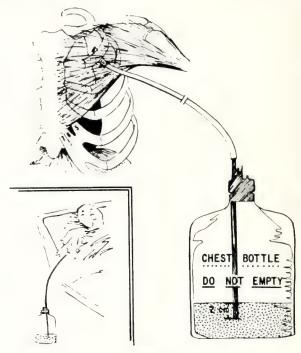


Figure 1

patient to suck air back into the chest, he must lift the column of water equal to the distance from the chest to the position of the bottle. For this reason, the bottle must be kept on the floor or at least two feet below the level of the patient's back. When the tube has been placed, the patient should be encouraged to cough.

Patients with tension pneumothorax may also have complications of multiple fractured ribs and an unstable chest wall. This problem requires some means of restoring stability and will be discussed in a later series.

One great source of the diseases of children is the unhealthiness of parents. It would be as reasonable to expect a rich crop from a barren soil, as that strong and healthy children should be born of parents whose constitutions have been worn out with intemperance or disease.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 26.

EDITORIALS 149

North Carolina Medical Journal

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MARCH, 1966

THE EXECUTIVE COUNCIL MEETING

The blizzard-like weather, actual and threatened notwithstanding, the regular quarterly meeting of the Executive Council convened in Pinehurst, January 29, with few absentees.

The Committee on Finance reported a modest surplus in the operation of the Society for 1965. It further recommended that the Society proceed with a plan, previously noted, to secure a charter for a medical foundation to provide a tax-exempt shelter for monies that may be realized from liquidation of property held by the Society and for future contributions that might become available to the foundation. The

Executive Council authorized legal counsel to apply for such a charter.

In February 1961, at a called meeting in Durham, the House of Delegates adopted a resolution not to accept vendor payment "at this time" under the then pending Kerr-Mills legislation. By vote of the Council, a recommendation will be made to the May meeting of the House of Delegates to rescind this 1961 action. It should be noted that Public Law 89-97 (Medicare) not only provides health care for Social Security recipients over age 65 under Title 18 but, in addition, under Title 19 extends Kerr-Mills to encompass all categories of public assistance. Thus Medicare actually established potential benefits for approximately 35,000,000 people.

Other actions taken in relation to Medicare include acceptance and approval of a proposal from the report of the Committee on Legislation that a bill be introduced into the 1967 General Assembly to establish immunity from suit of those physicians required to serve on hospital staff utilization and review committees. Such committees are a requirement for hospital participation in Medicare. The Council approved a report of the Committee on Utilization creating guidelines for hospital staff utilization and review committees.

Two members of the Medical Society were endorsed by the Executive Council for appointment to AMA Councils, Dr. John R. Kernodle to the Council on Medical Service and Dr. Edgar T. Beddingfield to the Council on Legislation.

J. S. R.

RENAL GLYCOSURIA

The discovery on routine urinalysis of reducing substances in the urine is a common clinical problem. Of course, all such substances are not glucose. The introduction of the glucose oxidase-coated tapes for urinetesting has made it possible to identify a reducing substance as glucose in one minute. The next step is to establish precisely for each patient the blood sugar level at which glucose spills over into the urine. An excellent article appearing elsewhere in

this issue emphasizes the importance of rigid criteria in characterizing the patient with renal glycosuria. When less strict diagnostic standards are employed, a very large proportion of patients labeled "renal glycosuric" will, in fact, be early diabetics.

A point that is sometimes overlooked is the usefulness of establishing the renal threshold for glucose in known cases of diabetes. The relatively low thresholds of the juvenile or pregnant diabetic are well known, A progressively higher threshold insidiously appears as chronic diabetic renal disease develops. In end-stage diabetic renal disease, one may see no sugar in the urine with blood sugar levels of 250 to 300 mg/100 ml, and paradoxically a marked increase in insulin sensitivity. There is a small group of diabetic patients in whom both a variety of renal glycosuria and diabetes mellitus co-exist. These patients spill sugar in their urine at normal blood sugar levels. On the ordinary diabetic diet, with its restriction of carbohydrate to 150-200 gm, these patients will be troubled by frequent hypoglycemic reactions and by a ready tendency to acidosis, because their urine loss of glucose (even with reasonable blood sugar levels) is so large that relatively little carbohydrate is available for oxidation. Multiple blood sugar determinations during a 24-hour period, together with a quantitative determination of the urine sugar, provide the most practical means of recognizing this small group of diabetics. The presence of 40 mg of glucose in the urine with blood sugar levels of 200-300 mg/100 ml simply indicates the need for more vigorous insulin therapy. The same 40 mg of glucose in the urine with blood sugars of 80-100 mg/100 ml in a diabetic is the clue that enables one to recognize co-existing renal glycosuria in diabetes. The treatment is simply to increase the amount of carbohydrate in the diet to 250 to 300 grams daily.

We physicians, perhaps, are too eager at times to classify a diabetic who proves difficult to manage as a labile diabetic. This comforting classification implies that the difficulty of management is inherent in the disease itself, but it does not relieve us of the obligation to look carefully in each labile diabetic for a reason for the lability. Rarely, it is co-existing renal glycosuria; often it is unrecognized hyperthyroidism or urinary tract infection; and commonly it arises from the patient's failing to know as much about his diabetes as we think we have taught him.

EMERY MILLER, M.D.

SICKENINGLY SWEET

Establishing a cause-and-effect relationship is one of the most difficult tasks of science, especially biologic science. It should therefore be no surprise that only now are artificial sweeteners becoming suspect as a cause of peculiar reactions in some of the people who take them in. For one thing, only recently have they been used in great quantities by the general public. In the past they were used by diabetics and weightwatching people of middle years and beyond. Under the impact of current advertising, their use in soft drinks puts them in the bodies of people from toddling age to wobbling age.

In a letter to the *JAMA* (194: 571-572, Nov. 1, 1965), Dr. E. Boros describes the manifold personal problems which calcium saccharinate and calcium cyclamate caused for him. He developed pruritus, rash, nocturia, vertigo, and a bad taste in his mouth. Despite these distressing manifestations he went to some pains to establish the artificial sweeteners as the cause of his trouble.

The July, 1965 issue of Current News in Dermatology describes several cases of saccharin sensitivity including irregularities of cardiac rhythm, urticaria, a shock-like state, and photosensitization. The newsletter describes one patient who developed sunlight sensitivity in response to artificial sweeteners, sulfonamides, and anti-diabetic agents. Several cases of urticarial reactions to these agents have come to our own attention, as well as patients developing photosensitivity when taking thiazide diuretics, which are also related to the sulfonamides. Our Russian colleagues have had their doubts about artificial sweeteners, and have banned all but saccharin from the market.

The sneaky thing about sensitivity to ar-

tificial sweeteners is that a patient usually will not mention them when asked if he is taking any drugs, especially if soft drinks are the vehicle. One must remember that those gay young things swilling diet drinks with abandon on TV commercials may be all broken out the next day. Let the drinker beware!

The President's Page

EDUCATION FOR THE HEALTH PROFESSIONS

I was privileged to attend the recent White House Conference on Health, which attracted more than 800 persons from virtually every health discipline and represented all health interests. The Conference was called by the President "to bring together the best minds and boldest ideas to deal with the pressing health needs of this Nation."

The Conference held discussions on (1) education for the health professions, (2) health care, (3) health protection focused on the barriers to high quality care, (4) the unavailability of services for many, (5) the urgent need for expanding research, and (6) new approaches in the fields of manpower and environmental health. clear that there is no single easy solution to the health problems of this Nation; rather, all the health disciplines, the community agencies and institutions, and the public must make a concerted attack on the many facets of the problem. This will require a public-private partnership at local, state, and national levels. In this message, only the first of these discussions will be considered-education for the health professions.

All panels provided a consensus that present methods of developing manpower for the health professions are insufficient and inadequate. The same lacks were noted with respect to current organization and methods for the delivery of health services.

Education for the health professions and their co-workers at all levels must be reexamined and strengthened. New and continuing incentives to attract people of all ranks, including the underprivileged, to the health field must be developed. It was brought out that educational institutions must become teaching centers for all the health professions. There is a great need for joint education of primary and auxiliary specialists. We must find positive means, not now available, to encourage persons of ability to move up the career ladder as their talents permit.

The panels emphasized the need to develop adequate guidelines for financing services provided by medical schools. Until it is recognized that support of education for health personnel is an integral part of the cost of health care, these costs will always be undersupported.

It was further agreed that the role of the health team requires better definition. There is an urgent need for a careful analysis of the skills and knowledge needed by each health worker. As national expectations rise and goals of achievement are developed, we must delineate manpower resource needs for all kinds of health workers. There is a particular need, it was brought out, to expand the concept of the physician-assistant, health visitor, or community health aide. The person with the necessary working knowledge of the patient as well as of the community can serve to extend the usefulness of the health team. In defining the role of such a health team, certain other vital questions are raised:

How can allied health professions best be educated and organized to provide the necessary comprehensive and continuing health services?

How can the artificial barriers which have prevented free mobility between the health professions be eliminated?

Can physicians be trained to use assistants, and will scientific colleagues and assistants be allowed to accept the ever-in-

creasing responsibility for appropriate decisions concerning individual patients?

Community Models

One means of acquiring the necessary data by which we can plan for the future would be establish community models that would serve to explore the interrelationships of the various health fields. These models would be community-based and strongly tied to community and university hospitals and, in turn, to the university. They would be centers of operational research at the community level and allow full utilization of the specialized competence of all members of the health team. Within this concept, appropriate guidelines for essential education in differing health skills could be determined. And at the same time, necessary services would be provided.

Such demonstration centers should serve as the hub for community education and for continuing education of all health-related professions within the area served. These units will be successful only if there is a major commitment by the health professions through their schools, societies and organizations; a major commitment of funds through private and public sectors; and a major commitment of all educational institutions to cooperate for the public benefit.

The university must assume and accept a much broader role than it now plays. Health care creates major opportunities for a university to move into new areas into which it has not ventured before. It must act as a catalyst. Universities will have to assume this role and cooperate with other education institutions and groups within the community, and accept full responsibility for basic and continuing education. In order to accomplish this there must be agreement and firm support outside and within the health professions.

In reaching these objectives, we must constantly strive to maintain a proper balance between public and private financing. Only so long as universities have freedom to maneuver in the use of funds will they be able to broaden and improve the quality of education for service and meet future needs in the health field.

Education for the health field is big business, and although sizeable funds are essential, it is recognized that money alone will not solve our problems. More careful planning for the intelligent and prudent use of available monies is necessary. The American people are prepared to pay more for the kind of health services they demand. They are awaiting an adequate plan to be implemented by a skilled and dedicated group.

GEORGE W. PASCHAL, JR., M.D.

The generality of people lay too much stress upon medicine, and trust too little to their own endeavours. It is always in the power of the patient, or of those about him, to do as much toward his recovery as can be effected by the physician. . . . I think the administration of medicine always doubtful and often dangerous, and would much rather teach men how to avoid the necessity of using them, than how they should be used.—William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc., Philadelphia, Richard Folwell, 1799, p 11.

PROGRAM

One Hundred Twelfth Annual Session
The Medical Society of the
State of North Carolina

ASHEVILLE, NORTH CAROLINA

Headquarters
BATTERY PARK
and
GEORGE VANDERBILT HOTELS

Saturday, April 30, 1966

9:00 A.M.

Executive Council Meeting
(Business of this Session may be continued Sunday morning at 10 o'clock)
(Battery Park - Grove Room)

10:00 A.M.

Registration Desk opens, Booth (Lower Lobby - Asheville City Auditorium) (Society Members, Delegates, Officials, Guests, Technical and Scientific Exhibitors will register in this Area) (Registration closes at 4:00 P.M.)

4:00 P.M.

Registration desk closes.

Sunday, May 1, 1966

10:00 A.M.

General Registration opens, Booth (Lower Lobby - Asheville City Auditorium) (Society Members, Delegates, Officials, Guests, Technical and Scientific Exhibitors will register in this Area)

2:00 P.M.

First Meeting of the Annual Meeting THE HOUSE OF DELEGATES of the Medical Society Donald B. Koonce, M.D., Speaker, presiding



Donald B. Koonce, M.D.

2:00 P. M.

Invocation:
Welcome:
(Agenda will be available)
(Asheville City Auditorium - Assembly Hall)

5:00 P. M.

Registration Desk Closes

5:30 P. M.

Social Hour & Dinner
University of Virginia Medical Alumni
Biltmore Forest Country Club
Co-Hosts: Edward Orgain, M. D., Durham
John Harloe, M. D., Charlotte
J. F. B. Camblos, M. D., Asheville
(See Mr. William Booth—Registration Area
for Information)

6:00 P. M.

House of Delegates recesses to Monday, May 2, 1966. (If Business of First Meeting is not concluded.)

Monday, May 2, 1966 8:30 A.M.

Scientific and Technical Exhibits open (Exhibit Ha!l - Asheville City Auditorium)

8:30 A.M.

General Registration opens, Booth
(Lower Lobby - Asheville City Auditorium)
(Society Members, Delegates, Officia's, Guests, Technical
and Scientific Exhibitors will register in this Area.)
(Auxiliary Members will register at the Holiday Inn)

9:00 A.M.

NORTH CAROLINA BOARD OF MEDICAL EXAMINERS (Meet for Business and Hearings) (Battery Park - Grove Room)

POSTGRADUATE AND AUDIO-VISUAL PROGRAM

John C. Grier, Jr., M.D., Chairman, Pinehurst Morning Session - East Ballroom - George Vanderbilt Paul McBee Abernethy, M.D., Burlington, Moderator

9:00 A.M.

MIGRAINE EQUIVALENTS

Complex nature of the migraine syndrome.

Differential diagnosis and therapy of ophthalmicprecordial-abdominal-and menopausal and menstrual
migraine are discussed.

(Monday, May 2, 1966—Continued)

9:30 A.M.

PHARMACOLOGIC THERAPY IN MENTAL ILLNESS Recent advances in the treatment of mental illness. Mechanism of action of psychotherapeutic agents and their relation to the dynamics of behavior and of emotional disorders.

10:15 A.M.

SOMEONE IS WATCHING

Various ways in which legal narcotics fall into the hands of dope addicts and peddlers through carelessness and false confidence. The need for diligent safeguarding of drugs.

10:35 A.M.

MEDICAL EXPERIMENTS FOR MANNED SPACE FLIGHT

Depicts the effects of prolonged weightlessness on flight crews. Methods and techniques in instrumentation, recording, and analytical equiptment. Physiological studies of demineralization, othostatic hypotension, the heart, hematology, metabolism, pulmonary function, otology, stress, and circadian dysrhythmia in weightless conditions.

11:05 A.M.

THAT THEY MAY LIVE

Shows how to apply direct artificial respiration in various emergency situations.

FIRST GENERAL SESSION Monday, May 2, 1966

Asheville City Auditorium - Assembly Hall

8:30 A.M.

Film

9:00 A.M.

Convene Session George W. Paschal, Jr., M.D., President



George W. Paschal, Jr., M.D., President

9:00 A. M.

Invocation:

Rev. Robert S. Busey,

Grace Covenant Presbyterian Church, Asheville

9:00 A.M.

REVISED CONCEPTS IN EMERGENCY MEDICAL CARE Francis C. Jackson, M.D., Pittsburgh, Pa.



Francis C. Jackson, M.D.

9:30 A.M.

THE PRESENT STATUS OF CLINICAL HOMOTRANSPLANTATION

Thomas E. Starzl, M.D., Denver, Colorado



Thomas E. Starzl M.D.,

10:15 A.M.

Break

10:30 A.M.

Address: James Z. Appel, M.D., President American Medical Association



James Z. Appel, M.D.,
President

American Medical Association

11:00 A.M.

Address Jacob Koomen, M. D. State Health Director



Jacob Kooman, M. D. State Health Director

11:30 A.M.

I'HE MEDICAL EXAMINER'S ROLE IN EXONERATION OF THE INNOCENT

Richard Ford, M.D., Boston, Mass.



Richard Ford, M.D.

12:00 Noon

Announcements
(Presentation of pictures; History of Medicine Parke, Davis & Company)

ADJOURNMENT

12:00 NOON

Luncheon North Carolina Pediatric Society Green Room - Battery Park

12:30 P. M.

N. C. State Commission for the Blind Business Meeting Buck's Restaurant

ALUMNI LUNCHEONS Monday May 2, 1966 - 1:00 P.M.

Duke University Medical Alumni Talmadge L. Peele, M.D., Secretary (George Vanderbilt - West Ballroom) University of North Carolina Alumni (Battery Park - Gold Room)

2:00 P.M.

HOUSE OF DELEGATES of the Medical Society reconvenes
(Asheville City Auditorium - City Hall)

POSTGRADUATE AUDIO-VISUAL PROGRAM

John C. Grier, Jr., M.D., Chairman, Pinehurst

2:00 P.M.

Afternoon Session - East Ballroom - George Vanderbilt Moderator: Marius H. Wells, M.D., Brevard

2:00 P.M.

CHRONIC BRONCHITIS - A TEAM AFFAIR

The team consists of the patient's General Practitioner, the Pathologist, the Chest Physician, the Bacteriologist, and the Physiotherapist. Modern management of chronic bronchitis. From an innocent "smoker's cough" to the terminal crippling disease.

2:35 P.M.

CLINICAL APPLICATIONS OF MICROPOROUS TAPES
IN WOUND CLOSURE

A comprehensive report on a new technique in wound closure with adhesive strips.

3:00 P.M.

DERMABRASION: A SURGICAL TECHNIQUE FOR IMPROVEMENT OF SKIN DISFIGUREMENTS

3:20 P.M.

LONG-TERM USE OF ANTICOAGULANTS

A controversial subject. Discussion by a panel of physicians with extensive experimental and clinical experience.

4:00 P.M.

A CASE FOR UNDERSTANDING

The necessity for rules and procedures if a hospital team is to function smoothly in primary interest of patient care.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Monday, May 2, 1966 - 2:30 P.M.

Vanderbilt Room - George Vanderbilt

William R. Hudson, M.D., Chairman, Durham

2:30 P.M.

PERIOSTEAL GRAFT TYMPANOPLASTY Rheudolph J. Wells, M.D., Greensboro (Monday, May 2, 1966—Continued)

2:50 P.M.

FACIAL PAIN

Carl A. Sardi, M.D., Greensboro

3:10 P.M.

PITUITARY ABLATION UTILIZING TRANS-SPHENOI-DAL YTTRIUM IMPLANTS

Blaine Nashold, Durham

3:30 P.M.

Break

3:45 P.M.

TRANSIENT ELEVATIONS OF INTRAOCULAR PRESSURE FOLLOWING BASAL IRIDECTOMY James P. Gills, Jr., M.D., Durham

4:05 P.M.

COMPARISON OF CLEAR CORNEAL AND CORNEO-SCLERAL CATARACT INCISIONS

Alan Davidson, M.D., New Bern

4:25 P.M.

Business Meeting

SECTION ON SURGERY

Monday, May 2, 1966 - 2:30 P.M.

Colin G. Thomas, Jr., M.D., Chairman, Chapel Hill

(Battery Park - Gold Room)

SYMPOSIUM: CURRENT TRENDS IN PERIPHERAL VASCULAR SURGERY

Moderator: George Johnson, Jr., M.D., Chapel Hill

TREATMENT OF:

VENA CAVAL INJURIES

Thomas E. Starzl, M.D., Denver, Colorado

ACUTE VENOUS OCCLUSION

Jesse H. Meredith, M.D., Winston-Salem

ACUTE ARTERIAL OCCLUSION

Joe W. Frazer, Jr., M.D., Greensboro

PENETRATING VASCULAR INJURIES AND THEIR MANAGEMENT

Horace G. Moore, Jr., M.D., Wilmington

FEMORO-POPLITEAL OBSTRUCTION

Stewart M. Scott, M.D., Oteen

ADJUNCTS TO THE SURGICAL TREATMENT OF PERIPHERAL VASCULAR DISEASE: HEPARIN, FIBROLYSIN, AND DEXTRAN

Donald Silver, M.D., Durham

SECTION ON PEDIATRICS

Monday, May 2, 1966 - 2:30 P.M.

Lawrence E. Metcalf, M.D., Chairman, Asheville

(Battery Park - Pisgah Room)

PANEL:

Psychiatric Aspects of Pediatrics

SECTION ON PUBLIC HEALTH AND EDUCATION

Monday, May 2, 1966 - 2:30 P.M.

J. U. Weaver, M.D., Chairman, Henderson (Battery Park - Rhododendron Room)

BUSINESS MEETING

SECTION ON ANESTHESIOLOGY

Monday, May 2, 1966 - 2:30 P.M.

C. Max Drummond, M.D., Chairman, Winston-Salem
(George Vanderbilt - Sun Dial Room)

DELIBERATE HYPOTENSION

James Esler, M.D., University of North Carolina, Chapel Hill

NEUROLEPT ANALGESIA

John C. Fox, M.D., Bowman Gray School of Medicine, Winston-Salem

SHORT BUSINESS MEETING

SECTION ON ORTHOPAEDICS AND TRAUMATOLOGY

(Parlor A. - Battery Park)

Monday, May 2, 1966 - 2:30 P.M.

Basil M. Boyd, Jr., M.D., Chairman, Charlotte

DISABILITY EVALUATION OF THE LOWER EXTREMITY

Henry D. Severn, M.D., Asheville

BRIEF DISCUSSION OF THE MEDICAL LEGAL CODE DISABILITY EVALUATION OF THE SPINE

Edwin H. Martinat, M.D., Bowman Gray, Winston-Salem

DISABILITY OF THE UPPER EXTREMITY

Stuart Gaul, Jr., M.D., Charlotte ROUND TABLE DISCUSSION

Moderator: Chalmers R. Carr, M.D., Charlotte

SECTION ON STUDENT AMA CHAPTERS IN NORTH CAROLINA

Monday, May 2, 1966 - 2:30 P.M.

(George Vanderbilt - West Ballroom)

J. William Futrell, Chairman, Durham

PANEL DISCUSSION "HEADACHE"

MODERATOR:

James F. Toole, M. D., Bowman Gray, Winston Salem

PANEL:

Duke Medical Student Bowman Gray Medical Student UNC Medical Student

Presentation of original papers by medical students from Bowman Gray, Duke and UNC. The papers will be judged and an award goes to the one judged the most outstanding.

5:00 P.M.

Registration booth closes

5:00 P.M.

Exhibits close, (Scientific and Technical)
(Exhibits under supervision of official watchmen)

5:00 P.M.

House of Delegates adjourns Annual Meeting

5:30 P.M.

Social Hour and Entertainment for Technical and Scientific Exhibitors

By: Medical Society

Roof Garden - Battery Park

6:00 P. M.

SOCIAL HOUR - Vanderbilt Medical Center Alumni, Grove Room - Battery Park

6:30 P.M.

SOCIAL HOUR - Medical College of Virginia Alumni (Bucks Restaurant - Red Carpet Room)

7:30 P.M.

DINNER - Medical College of Virginia Alumni (Bucks Restaurant - Red Carpet Room)

SECTION ON STUDENT AMA CHAPTERS DINNER

Monday, May 2, 1966 - 7:00 P.M.

(George Vanderbilt - West Ballroom)

DINNER MEETING:

Invocation:

Introduction of Guests: J. William Futrel, Chairman Guest Speaker:

ADDRESS: "Medicine In Viet Nam"

J. Ralph Dunn, M. D.

Tarboro

Award for Outstanding Student Paper

8:00 P. M.

Meeting Board of Directors North Carolina Med Pac (Grove Room - Battery Park)

Tuesday, May 3, 1966 7:30 A.M.

DUTCH BREAKFAST

(Battery Park - Gold Room)
Rachel D. Davis, M.D., Chairman, Committee on
Marriage Counselling, presiding

SPEAKER: Isadore Rubin, Ph.D., Editor SEXOLOGY MAGAZINE New York

8:00 A.M.

Medical Women - Dutch Breakfast
ALL WOMEN DOCTORS CORDIALLY INVITED TO
ATTEND

8:30 A.M.

REGISTRATION opens, Booth (Lower Lobby, Asheville City Auditoriumm)

8:30 A.M.

Scientific and Technical Exhibits Open (Exhibit Hall - Asheville City Auditorium)

POSTGRADUATE AUDIO-VISUAL PROGRAM

John C. Grier, Jr., M.D., Chairman, Pinehurst

9:00 A.M.

Morning Session - East Ballroom - George Vanderbilt Moderator: John C. Grier, Jr., M.D., Pinehurst

(Tuesday, May 3, 1966—Continued)

9:00 A.M.

HELPING HANDS FOR JULIE

Career opportunities in medicine and health. The helping hands aiding the doctors — nurses, medical technologists, x-ray technicians, and the medical record librarian. A dramatic film.

9:30 A.M.

NATIONAL INSTITUTES OF HEALTH

Describes the mission, development, and historical background as a part of the Public Health Service. The role in unfolding of new knowledge through the laboratories and through the support of medical research and related activities in non-Federal Institutes.

10:00 A.M.

EXPEDITION: CITY FALLOUT

Effects of air pollution upon an urban environment.

Mass transportation and concentrations of industrialization may overtax the limited supply of available air. How air pollution can affect the normal function of the lungs.

10:30 A.M.

IF I HAD AN ULCER

A lively and instructive presentation in diagnosis and management of peptic ulcers. Major factors of secretion, acidity, malignancy, and recurrence in gastric and duodenal lesions.

11:00 A.M.

FIBERSCOPIC EXAMINATION OF THE STOMACH AND CINEGASTROSCOPY

The fiberscope and its advantages in gastric examinations. Ulcers studied in vivo. The progress of medical management of gastric lesions.

SECOND GENERAL SESSION

Tuesday, May 3, 1966

(Asheville City Auditorium - Assembly Hall)
8:30 A.M.

9:00 A.M.

Convene Session George W. Paschal, Jr., M.D., President

9:00 A.M.

SYMPOSIUM ON PULMONARY INSUFFICIENCY MODERATOR: Joseph S. Hiatt, Jr., M.D., Pinehurst



Joseph S. Hiatt, Jr., M.D.

ROENTGENOGRAPHIC DIAGNOSIS Charles A. Bream, M.D., Chapel Hill



Charles A. Bream, M.D.

PULMONARY DISEASE IN CHILDHOOD William W. Waring, M.D., Associate Professor of Pediatrics, Tulane University School of Medicine,



William W. Waring, M.D.

CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA

Herbert O. Sieker, M.D., Durham



Herbert O. Sieker, M.D.

THE ROLE OF SURGERY IN PULMONARY INSUFFICIENCY

Howard H. Bradshaw, M.D., Winston-Salem



Howard H. Bradshaw, M.D.

10:30 A.M.

BREAK

11:00 A.M.

PANEL DISCUSSION: "PULMONARY DISEASE"

(Questions from audience with answers by the Panel)

Moderator: Joseph S .Hiatt, Jr., M.D.

Panel:

Charles A. Bream, M.D.

William W. Waring, M.D.

Herbert O. Sieker, M.D.

Howard H. Bradshaw, M.D.

12:00 Noon

Annual Address of the President George W. Paschal, Jr., M.D., Raleigh

12:30 P.M.

ANNOUNCEMENTS

ADJOURNMENT

ALUMNI LUNCHEONS

Tuesday, May 3, 1966 - 1:00 P.M.

Wake Forest College - Bowman Gray Alumni Association

(Battery Park - Gold Room)

UNC Medical Alumni Association (West Ballroom - George Vanderbilt)

N. C. Academy of Preventive Medicine (Battery Park - Green Room)

POSTGRADUATE AUDIO-VISUAL PROGRAM

John C. Grier, Jr., M.D., Chairman, Pinehurst

2:00 P.M.

Afternoon Session - East Ballroom - George Vanderbilt Moderator: William W. Shingleton, M.D., Durham

2:00 P.M.

THE CRY FOR HELP

Designed to develop a feeling of concern and understanding in handling the suicidal person. Presents some of the major causes of suicide and problems of handling.

2:35 P.M.

AERO MEDICAL RESEARCH

Intensive research program of Aero Medical Laboratory, Wright Air Development Center. Actual tests and research necessary for a pilot to withstand the rigors of high speeds, high altitudes, and intricate maneuvers.

3:10 P.M.

G-FORCES

The effects of the law of gravity on man and man's efforts to explore space. Effect of linear, radial, and angular acceleration on human body. Problems of weightlessness, acceleration endurance in 3-stage rocket flights, buffeting, tumbling, and deceleration.

3:40 P.M.

A MATTER OF FACT

Shows how an inadequate post-mortem examination can have far reaching effects, even to the point of convicting innocent men of murder. The medical examiner system versus the coroner system.

4:10 P.M.

SKIN BANK STORAGE OF POST-MORTEM HOMO-GRAFTS: METHODS OF PREPARATION, PRESERVATION, AND USE

Details of the establishment of a skin bank and of the storage and use of the grafts.

Durham

(Tuesday, May 3, 1966—Continued)

4:35 P.M.

THE FOUR DAYS OF GEMINI IV

The launch of Gemini IV from Cape Kennedy on June 3, 1965. Pilot White strolling in space (extra-vehicular activity) while conversing with Command Pilot McDevitt. The Twin Astronauts worked, ate, slept, and performed 11 measurements and photographic experiments, and 10 spacecraft experiments during the 62 revolutions. Total flight time 97 hours and 57 minutes.

SECOND MEETING OF THE HOUSE OF DELEGATES

Tuesday, May 3, 1966 - 2:30 P.M.

(Asheville City Auditorium - Assembly Hall)

(Agenda Will Be Available)

SECTION ON GENERAL PRACTICE OF MEDICINE

Tuesday, May 3, 1966 - 2:30 P.M.

(Battery Park - Gold Room)

Hugh A. Matthews, M.D., Chairman, Canton

NATURE AND DESTINY OF GENERAL PRACTICE Hugh A. Matthews, M. D., Canton

POSSIBLE ROLE OF THE FAMILY DOCTOR IN AC-CIDENT PREVENTION

R. Vernon Jeter, M. D., Plymouth

POSSIBLE ROLE OF THE FAMILY DOCTOR IN COURTSHIP AND MARRIAGE

Ernest H. Stines, M.D., Canton

POSSIBLE ROLE OF THE FAMILY DOCTOR IN THE SOCIAL PROBLEM OF CHILD ABUSE

Philip E. Dewees, M. D., Sylva

POSSIBLE ROLE OF THE FAMILY DOCTOR IN AL-COHOLISM

Ralph N. Feichter, M. D., Waynesville

SECTION ON INTERNAL MEDICINE

Tuesday, May 3, 1966 - 2:30 P.M.

(Parlor A - Battery Park)

Joseph B. Stevens, M.D., Chairman, Greensboro

2:30 P.M.

CONGENITIAL AND ACQUIRED HEART DISEASE - WHEN IS THERE NEED FOR REFERRAL?

Robert Headley, M.D., Assistant Professor of Medicine, Bowman Gray, Winston-Salem

3:00 P.M.

THE CARDIAC INTENSIVE CARE UNIT
Fred W. Schoonmaker, M.D., Duke Medical Center,

3:30 P.M.

GASTRO-INTESTINAL COMPLICATIONS OF ANTICOAGULATION THERAPY

Benjamin Vatz, M.D. and Howard Wainer, M.D., Greensboro

4:00 P.M.

CONTINUING EDUCATION FOR THE INTERNIST IN NORTH CAROLINA

James M. Alexander, M.D., Charlotte

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday, May 3, 1966 - 2:30 P.M.

(Battery Park - Rhododendron Room)

Lewis S. Rathbun, M.D., Chairman, Asheville

THE BIRTH CONTROL PILLS

Henry O'Roark, M.D., Dept. of Obstetrics & Gynecology, Bowman Gray, Winston-Salem

INTRA-UTERINE CONTRACEPTIVE DEVICES

James F. Donnelly, M.D., State Board of Health, Raleigh

THE ROLE OF THE DEPARTMENT OF PUBLIC WELFARE IN FAMILY PLANNING

Mr. Wallace H. Kuralt, Director, Department of Welfare, Mecklenburg County, Charlotte

TUBAL LIGATION

Lewis S. Rathbun, M.D., Asheville

SECTION ON NEUROLOGY & PSYCHIATRY

Tuesday, May 3,1966 - 2:30 P.M.

(Battery Park - Pisgah Room)

Robert N. Harper, M.D., Chairman, Raleigh

PANEL DISCUSSION:

Moderator: Robert N. Harper, M.D., Raleigh

"THERAPEUTIC ABORTION, WHERE DOES THE PROFESSION STAND?"

PANEL:

Kenneth C. Penegar, M.D., Assistant Professor of Law, University of North Carolina School of Law, Chapel Hill

Richard C. Proctor, M.D., Professor and Chairman, Department of Psychiatry, Bowman Gray, Winston-Salem

John B. Reckless, M.D., Assistant Professor of Psychiatry, UNC School of Medicine, Chapel Hill Robert A. Ross, M.D., Professor of Obstetrics, UNC

School of Medicine, Chapel Hill

SECTION ON RADIOLOGY

Tuesday, May 3,1966 - 2:30 P.M.

(George Vanderbilt - West Ballroom)

Everett H. Schultz, M.D., Chairman, Chapel Hill

MOVIES:

MODERN OPERATIVE CHOLANGIOGRAPHY PRESACRAL PNEUMOGRAPHY RENAL ANGIOGRAPHY

LYMPHOGRAPHY IN FEMALE GENITAL CANCER

PANELISTS:

Stewart Lee Moring, M.D., Rutherfordton Joseph E. Whitley, M.D., Winston-Salem Everett H. Schultz, Jr., M.D., Chapel Hill

SECTION ON PATHOLOGY

Tuesday, May 3, 1966 - 2:30 P.M.

(George Vanderbilt - Vanderbilt Room)

Donald S. Morris, M.D., Chairman, Winston-Sa'em

HYPERBARIC OXYGEN TOXICITY

Joseph Douglas Balentine, M.D., Duke Medical Center, Durham

PITFALLS IN IDENTIFICATION OF APTHOENIC FUNGI

Bernard F. Fetter, M.D., Duke Medical Center, Durham

THE CHARACTERISTICS OF METOSTASZING CARCINOMA OF THE SKIN

Herbert Z. Lund, M.D., Moses H. Cone Hospital, Greensboro

LEAD NEPHROPHEHY

Robert A. Goyer, M.D., UNC School of Medicine, Chapel Hill

FAMILIAL POLYPOSIS: A CLINICAL, PATHOLOGICAL, AND CYTOGENIC STUDY

William W. McLendon, M.D., Laura G. Anderton, Ph.D., and Carroll C. Lupton, M.D., Greensboro 5:00 P.M.

Registration closes

5:00 P.M.

Exhibits close

5:00 P.M.

Audio-Visual Program Closes

PRESIDENT'S DINNER

Tuesday, May 3, 1966

Asheville City Auditorium - Assembly Hall

7:00 P.M.

BANQUET (Admission by ticket only)

TOASTMASTER: Robert A. Ross, M.D., Chapel Hill

INVOCATION:

Rev. Hoyt Blackwell

President, Mars Hill College

Mars Hill

7:30 P.M.

Presentation of Guests

7:40 P.M.

Presentation of President's Jewel Charles W. Styron, M.D., Raleigh

7:50 P.M.

Installation of President-Elect Frank W. Jones, M.D.,

Administration of Authorized Oath of Office

An Address in Acceptance: Frank W. Jones, M.D., President



Frank W. Jones, M.D. President

8:15 P.M.

Recognition of FIFTY-YEAR CLUB and presentation of Fifty-Year Club Pins and Certificates

(Tuesday, May 3, 1966—Continued)

8:30 P.M.

ADDRESS: AMERICA'S SPACE EFFORT TO NOW - WHERE WILL IT GO?

Colonel John "Shorty" Powers

Boston, Massachusetts



Colonel John "Shorty" Powers

10:00 P.M.-2:00 A.M.

PRESIDENT'S BALL (Assembly Hall - Asheville City Auditorium) (Music by Pat Dorn & Orchestra)

Wednesday, May 4, 1966

9:00 A.M.

Registration Desk open, booth (Lower Lobby - Asheville City Auditorium)

9:00 A.M.

Scientific and Technical Exhibits Open (Asheville City Auditorium - Exhibit Hall)

THIRD GENERAL SESSION

Wednesday, May 4, 1966

(Asheville City Auditorium - Assembly Hall)

8:30 A.M.

Film

8:45 A.M.

CONVENE:

W. Otis Duck, M. D., 1st Vice President

CONJOINT SESSION:

North Carolina State Board of Health

Lenox D. Baker, M.D., Durham, President, will preside over the meeting of the Medical Society of the State of North Carolina and the State Board of Health.

Jacob Koomen, M.D., Acting State Health Director, reporting.

9:15 A.M.

Presentation of Aesculapius Award - Robert E. Miller, M.D., Chairman, Committee on Scientific Exhibits

9:20 A.M.

Presentation of AMA-ERF Checks to: Duke, UNC and Bowman Gray Medical Schools

Harry B. Underwood, M.D., Chairman, Committee on AMA-ERF

9:25 A.M.

Recognition and Presentation of:

Moore, County, Wake County and Gaston County Awardees

Lester A. Crowell, Jr., M.D., Chairman, Lincolnton

9:30 A.M.

ADDRESS: DIPLOMA SCHOOL OF NURSING PROBLEMS
RELATING TO THE SHORTAGE OF REGISTERED
NURSES

Thomas Hale, Jr., M.D. Administrative Vice-President Albony Medical Center Hospital Albany, New York



Thomas Hale, Jr., M.D.

10:00 A.M.

Break

10:15 A.M.

Panel: The Heart, Cancer, Stroke Program and Its Implications for North Carolina Chairman: George W. Paschal, M.D., Raleigh

PANEL:

William G. Anlyan, M.D., Dean, Duke University Medical School, Durham

Manson Meads, M.D., Dean, Bowman Gray School of Medicine, Winston-Salem

Isaac M. Taylor, M.D., Dean, UNC School of Medicine, Chapel Hill

and

Hubert McN. Poteat, Jr., M.D., Smithfield Ladd W. Hamrick, Jr., M.D., Concord Robert H. Shackelford, Jr., M.D., Mt. Olive

11:15 A.M.

ELECTIONS:

North Carolina Medical Journal - Editorial Board

2—4-year terms

North Carolina Board of Medical Examiners

2-6-year terms

11:25 A.M.

Installation of Officers 1966 House of Delegates George W. Paschal, Jr., M.D. 11:30 A.M.

Remarks by President Frank W. Jones, M.D.

12:00 Noon

Exhibits close

12:00 Noon

Registration Desk closes

12:00 Noon

Presentation of Prizes

ADJOURN SINE DIE

The ignorant are always most apt to tamper with medicine, and have the least confidence in physicians. Instances of this are daily to be met with among the ignorant peasants, who, while they absolutely refuse to take a medicine which has been prescribed by a physician, will swallow, with greediness, any thing that is recommended to them by their credulous neighbors. — William Buchan, M.D.: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p 18.

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THOMAS F. COATES, JR., M.D. Assistant Medical Director

J. McDERMOTT BARNES, M.D. Associate

R. H. CRYTZER Administrator

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Bulletin Board

Coming Meetings

Bowman Gray School of Medicine of Wake Forest College, Postgraduate Course in Obstetrics and Pediatrics—Winston-Salem, April 12-14.

North Carolina Chapter, American College of Surgeons—Robert E. Lee Hotel, Winston-Salem, April 14-16.

North Carolina Tuberculosis Association, Annual Meeting—Grove Park Inn, Asheville, April 21-22. North Carolina Physical Therapy Association

meeting—Hotel Jack Tar, Durham, April 23.
Southeastern Psychiatric Association — Pine

Southeastern Psychiatric Association — Pine Needles Lodge, Southern Pines, April 24-27.

Medical Society of the State of North Carolina, 112th Annual Session—City Auditorium, Asheville, April 30 - May 4.

North Carolina Heart Association, 17th Annual Meeting—Hotel Jack Tar, Durham, May 18-19.

American College of Physicians, Postgraduate Course on Neurology for the Internist—Hotel Robert E. Lee, Winston-Salem, June 16-17.

Tri-State Medical Association, Annual Meeting—Carolinian Hotel, Nags Head, June 27-29.

New Hanover County Medical Symposium — Blockade Runner Hotel, Wrightsville Beach, August 12-13.

North Carolina Association for Retarded Children
—Jacksonville, September 16-17.

Charlotte Postgraduate Seminar—Presbyterian Hospital, Charlotte, September 21-22.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. William S. Pearson, who has served for the past 18 months as clinical director of chronic services and director of training at Broughton Hospital, Morganton, recently joined the faculty of the Bowman Gray School of Medicine. His appointment as instructor in psychiatry and director of psychiatric education became effective January 1.

Dr. Pearson, who succeeds Dr. Edward S. Carr, will be in charge of the teaching program in psychiatry for medical students and postdoctoral trainees. Dr. Carr took a two-year leave of absence to continue studies in adolescent psychiatry at the Jungian Institute, Zurich, Switzerland.

A native of Statesville, Dr. Pearson holds the B.S. and M.D. degrees from the University of North Carolina. He interned at Cone Memorial Hospital in Greensboro and completed residency training in psychiatry at Dorothea Dix Hospital in Raleigh.

Dr. Courtland H. Davis, Jr., associate professor of neurosurgery, is winding up a two-month trip to the Far East where he is serving as consultant

in neurosurgery at hospitals in Malaysia and India.

His trip is sponsored by the Congress of Neurological Surgeons and supported by a fellowship from the Vocational Rehabilitation Service of the U. S. Department of Health, Education and Welfare.

During his tour, Dr. Davis served as visiting professor of neurosurgery at the MEDICO Neurosurgery Center in Kuala Lampur, Malaysia, and is now consultant in neurosurgery at the Christian Medical College and Hospital, Vellore, South India. He plans a brief visit to Chulalongkorn Hospital in Bangkok, Thailand, before returning to the Bowman Gray School of Medicine.

Eight North Carolina college students have been selected to receive Reynolds Scholarships for study at the Bowman Gray School of Medicine.

The scholarship program, sponsored by the Z. Smith Reynolds Foundation, will provide each recipient \$14,000 during his four years of medical school. In addition, the foundation will supplement each scholar's internship salary, during his fifth year of medical education, providing him an income of \$5,000 for that year.

Selection of the scholars is made by the medical school's committee on admissions on the basis of character, scholarship, potential as a physician, and financial need.

The scholars, who will enter the Bowman Gray School of Medicine in September, include Robert G. Austin, Jr. of Monroe, a senior at Davidson College; J. William Eakins of Ivanhoe, a junior at the University of North Carolina; Wilson O. Elkins of Greensboro, a junior at the University of North Carolina; Jimmy G. Harris of Valdese, a senior at Wake Forest College; Hersey E. Miller of Waynesville, a senior at Wake Forest College; John C. Morrison, Jr. of Raleigh, a senior at the University of North Carolina; P. Samuel Pegram, Jr. of Greensboro, a senior at the University of North Carolina; and Miss Carolyn L. Ray of Burnsville, a senior at Duke University.

The formal presentation of the scholarships will be made May 13 at the annual awards banquet in Winston-Salem.

During the nine years the scholarship program has been in effect, the Z. Smith Reynolds Foundation has awarded more than \$1,350,000 in scholarships to support medical education.

Dr. I. Meschan, professor and chairman of the Department of Radiology, was the Kirklin-Weber Memorial Visiting Professor of Radiology January 27-28 at Mayo Clinic. The professorship, established in 1959, each year brings two nationally prominent radiologists to the Mayo Clinic to present lectures and seminars.

Dr. Meschan delivered a lecture on "Renal Phy-

siologic and Pharmacologic Concepts Basic to Roentgenologic Diagnosis" and presented two seminars. His seminar topics were "Roentgen Diagnosis of Partially Calcified Tumors of the Brain" and "Roentgen Diagnosis of Atropic Gastritis of the Stomach."

* * *

Dr. Clark E. Vincent, professor of sociology, was recently appointed to a preparatory commission for a national conference on "Psychiatry and Medical Education."

The conference, sponsored by the American Psychiatric Association in cooperation with the Association of American Medical Colleges, will be held March 6-10, 1967.

Eight commissions have been appointed to conduct a one-year study prior to the conference. Dr. Vincent will serve on the Commission on Resources.

* * *

Dr. Quentin N. Myrvik, professor and chairman of the Department of Microbiology, has been elected to a two-year term as a member of the Council of the Reticuloendothelial Society.

* * *

Dr. William H. Boyce, professor of urology, presented a paper on "Problems in Surgery of Renal Calculi" and served as moderator for a panel discussion on "Urologic Problems in the Newborn" at a meeting of the American College of Surgeons, January 31-February 2 in Houston, Texas.

* * *

Dr. Frank C. Greiss Jr., assistant professor of obstetrics and gynecology, participated in a meeting of the South Atlantic Association of Obstetricians and Gynecologists January 26-29 in Bal Harbour, Fla. He presented a paper on "Pressure-Flow Relationship in the Gravid Uterine Vascular Bed."

* * *

Dr. Felda Hightower, associate professor of surgery, addressed a general surgery session at the sectional meeting of the American College of Surgeons January 13-15 in Bal Harbour, Fla. He spoke on "Preoperative Evaluation of the Elderly Patient."

* *

Dr. Clark E. Vincent, professor of sociology, participated in a symposium on "Sexual Problems in Clinical Practice" January 16 at the University of Colorado School of Medicine. He spoke on "Physician Counseling in Extramarital Pregnancies." Dr. Vincent also presented a paper on "Physician-Patient Communication" at a January 17 meeting of the Boston Gynecological Society, Boston, Mass.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Chancellor Paul F. Sharp, with the approval of President William Friday and the trustees' executive committee, has announced the following personnel changes at the UNC School of Medicine:

Dr. Nathan S. Womack will retire as chairman of the Department of Surgery in the School of Medicine, effective July 1, but will continue in service as a professor of surgery in the medical school.

The trustees accepted the resignations of Dr. Syndenham B. Alexander, assistant administrator in Health Affairs, who has accepted a position at the University of Alabama, and of Dr. Robert Zeppa, of the School of Medicine, who goes to the University of Miami.

Promoted to associate professor were the following: Dr. William Blythe, Medicine; Dr. John K. Spitznagel, Bacteriology and Medicine; Dr. Richard I. Walker, Medicine. Promoted to the rank of assistant professor were: Drs. Robert R. Huntley, Preventive Medicine and Medicine; Sarah A. Miller, Physical Therapy, and S. W. Nye, Pathology.

Dr. Louis Selig Harris, formerly of the Sterling-Winthrop Research Institute in New York, joined the faculty of the School of Medicine as an associate professor, effective January 1, 1966.

Dr. Philip F. Hirsch, former research fellow at Erandeis University in New York, became an associate professor in the Medical School, effective January 11, 1966.

Dr. Mary Ellen Jones becomes an associate professor in the School of Medicine, effective July 1, 1966. She is now at Brandeis University in New York. Her professional name is Dr. Mary Ellen Jones and she is married to Dr. Paul F. Munson, who is the new chairman of the Department of Pharmacology in the Medical School.

Dr. George C. Ham, clinical professor of psychiatry and former chairman of the Department of Psychiatry at the University of North Carolina School of Medicine, is on a seven-week world tour as a consultant for the National Institute of Mental Health, the Peace Corps and other agencies.

*

His tour will include Honolulu, Japan, Hong Kong, Bangkok, Ceylon, India, Nepal, Kenya, Ethiopia, Israel, Greece, and Italy.

While in India he will visit his daughter and son-in-law, Sue and Fred Todd, who have been with the Peace Corps in Etwah, India, since September, 1965.

Dr. Mario C. Battigelli, 38-year-old native of Florence, Italy, has joined the medical and public health faculties at UNC. His special interests are in the environmental factors of disease, chest diseases and lung functions.

Dr. Battigelli has been on the faculty of the Graduate School of Public Health at the University of Pittsburgh since 1958. He was awarded his master's degree in public health there in 1957. For six years he was assigned to the Clinica del Lavoro at the University of Milan in Milan, Italy. He received his medical degree in 1951 from the University of Florence in Florence, Italy.

A research laboratory for improving biochemical tests used to detect brain-damaging disorders in newborn babies will be in operation at the University of North Carolina in Chapel Hill early this year.

The Children's Bureau of the U. S. Department of Health, Education, and Welfare has approved \$96,600 for the first nine months of a proposed five-year research program to be known as "Automated Detection of Neurometabolic Disorders."

Dr. George K. Summer, pediatric biochemist, and Dr. John B. Hill, pharmacologist, both of the UNC School of Medicine, are co-directors of the project.

One of their major tasks will be to adapt existing biochemical tests for inherited metabolic disorders to automation in order that the tests can be used to screen large numbers of babies.

Dr. Summer said that an apparent need exists for large-scale, research-oriented screening programs, and methods to meet this need must be developed.

The energy-producing system of animal cells is undergoing a biochemical study at the UNC School of Medicine under a \$30,000 federal grant.

The grant was transferred here from the University of Miami School of Medicine when Dr. Albert R. Krall, the principal investigator, joined the UNC departments of psychiatry and biochemistry.

Dr. Krall's study of "pure brain mitochondria" represents a search for the basic biochemical properties of the tiny, sausage-shaped "cells within cells" which provide the energy for cells to grow and reproduce.

"Until we understand the basic properties of mitochondria," Dr. Krall said, "we can't completely understand the action of nerve cells."

His major interest is in the mitochondria of the brain because their activity is essential to the functioning of the brain. However, he also is studying the mitochrondia of the liver, kidney and heart for comparison to see what may be unique about brain mitochondria.

Dr. Krall is a native of Eaton, Ohio, and received his Ph.D. in biochemistry from the University of Wisconsin. He was a senior biochemist with the Research Institute for Advanced Studies (a division of the Martin Company) for four years before joining the University of Miami School of Medicine in 1960.

Dr. Syndenham B. Alexander, assistant admin-

istrator of the Division of Health Affairs at the University of North Carolina in Chapel Hill since 1956, has resigned to join the main campus staff of the University of Alabama in Tuscaloosa.

In the new position he will be director of the Student Health Service, professor of medicine, and professor of preventive medicine. He will also advise and assist, in cooperation with the University of Alabama Medical Center, in developing health-related academic programs on the main campus.

The National Science Foundation has awarded \$84,000 to the University of North Carolina in Chapel Hill to purchase equipment for biochemical research in a variety of fields.

Dr. J. Logan Irvin, chairman of the Department of Biochemistry at the UNC School of Medicine, said that five major pieces of research equipment will be purchased: a spectro-polarimeter; a spectro-fluorometer; a recording ultravioletvisible spectro-photometer; an infrared spectrophotometer; and a scintillation spectrometer.

The equipment will be shared by the entire department.

Dr. Irvin is studying histones and, with J. H. Im, is interested in the structure of the enzyme, ribonuclease.

Dr. Jan Hermans is working on the structure of pigments in the blood and muscles which transport oxygen; Dr. John Wilson and Dr. Edward Glassman are working on RNA in the brain and its relationship to learning and memory; Dr. Billy Baggett is studying steroid hormones; Dr. C. E. Anderson and Dr. Claude Piantadosi are interested in the metabolism of fatty substances in the brain and liver; Dr. Fred Bell is doing basic research on protein synthesis; and Dr. James White is delving into the mode of action of antibiotics.

Dr. Ralph Penniall is studying energy transfer in cell nuclei, while Dr. David J. Holbrook is investigating membrane transport in the nuclei.

Dr. George K. Summer is working on detection techniques for hereditary defects related to mental retardation in children, and Dr. Michael K. Berkut is studying the mechanisms of calcium deposits in body tissues.

Ear specialists from the two Carolinas and Virginia were introduced to an instrument for detecting hearing loss during a two-day lecture and demonstration at the University of North Carolina Hearing and Speech Center, January 19 and 20.

Dr. Alan S. Feldman, an otolaryngologist at the State University of New York, conducted a workshop on use of the Zwislocki acoustic bridge.

A Zwislocki bridge has been purchased and soon will be added to the hearing tests.

The University of North Carolina in Chapel Hill has a child psychiatry consulting program so unusual that the Governor of South Carolina sent a special commission here to observe it as a "unique University-community interaction."

The Child Psychiatry Unit of the N. C. Memorial Hospital, directed by Dr. Rex W. Speers, has been working very closely with several communities in the state, trying to help children who pose behavioral problems.

Often, when child behavior in schools is involved, relations between hospital consultants and a community are strained. But Dr. Eric Schopler, director of Child Research at the hospital, and Miss Claudeline Lewis, chief social worker for the Child Psychiatry Unit, are finding that there is very enthusiastic acceptance of the hospital's child psychitary programs in almost all the communities they serve.

"Both Dr. Schopler and myself," says Miss Lewis, "have worked in similar programs out of state, but the community co-operation here in North Carolina is outstanding."

Dr. Schopler consults with superintendents, principals, and teachers in many schools across the state. When a child presents a serious problem to to the school, there is a conference with the parents, and then the school, the doctor, and the parents try to work out a way to give the child a complete education.

The longer a patient has diabetes, the more careless he's likely to become about the important chore of measuring his doses of insulin.

This is one of several medically discouraging facts revealed at the UNC School of Medicine following a study of adult diabetics in four settings—in two university medical centers, in a private practice, and in a prepayment health plan group.

The study has created serious doubt that diabetes is as firmly under control among its estimated 1.6 million known victims as generally believed.

Dr. T. Franklin Williams of the departments of medicine and preventive medicine, reporting for a five-member study team, said that medical scientists and practicing physicians still don't know enough about the biological nature of diabetes and this is the major reason the disease is not well controlled in many patients.

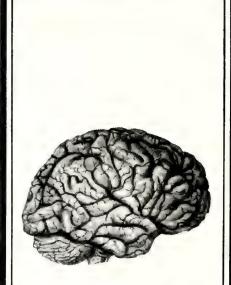
A new loan fund has been established at the University of North Carolina to aid medical students who need financial assistance in order to complete their medical training.

The Lenoir-Greene-Jones Counties Medical Society began the Dr. B. C. West Memorial Loan Fund with a gift of \$500. Dr. West, who was from Kinston, was an alumnus of the University. His friends and colleagues contributed the money to honor his memory.

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of extremities.

For the present, the funds will be used to match money made available by the federal government to the University in the Health Professions Loan Program for medical students. This matching at the ratio of nine to one will make a total of \$5000 available for loans to medical students as a result of the gift to the new fund.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The commonly held view that King George III, whose policies led the American Colonies to rebel, was insane is being challenged by two British psychiatrists, one of whom will deliver the Trent Lecture on the History of Medicine at Duke University April 27.

Dr. Richard Hunter of the National Hospital for Nervous Diseases, London, and his mother, Dr. Ida Macalpine, now retired, have stirred up a controversy in British medicine by contending that the King suffered from porphyria, a rare metabolic disorder not fully understood even today. Dr. Hunter will give the Duke lecture.

Historians have always believed that Britain's King George III was mentally ill. And many of the King's actions indicated that this was so. But now Dr. Hunter and his mother, who formerly served at St. Bartholomew's Hospital, London, claim that

acute intermittent porphyria upset the royal nervous system so much that the much-maligned monarch was delirious.

The two doctors claim their finding may necessitate revision of historical judgements and notions concerning the character and conduct of the King.

Dr. Zoltan J. Lucas, a new faculty member at Duke University Medical Center, has been given a three-year grant totaling \$50,000 by the National Institute of Arthritis and Metabolic Diseases for research in the field of tissue transplantation.

Dr. Lucas, an assistant professor of surgery at Duke and clinical investigator at Durham Veterans Administration Hospital, came here two months ago from Stanford University, Palo Alto, Calif.

His particular area of research is in biochemistry. In collaboration with Dr. Bernard Amos, professor of immunology at Duke, he is specifically trying to determine what causes changes in human blood lymphocytes—changes that are believed responsible for the rejection of some grafts in kidney transplantation.

Dr. Benjamin F. Trump has come to join the Duke faculty as an associate professor of pathology from the University of Washington, Seattle, where he had been an assistant professor of pathology since 1963.



litus, or vertigo.

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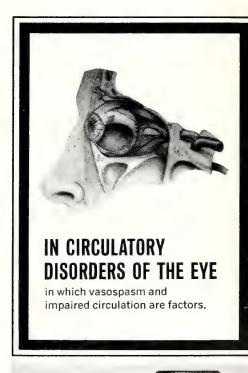
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Dr. Trump received his M.D. degree from the University of Kansas School of Medicine in 1957. He joined the University of Washington as a research associate in anatomy in 1959.

Primary interest of the new faculty member is in studying structural and functional changes in the cells in the kidneys after various types of injuries. He has been involved in this research project on a National Institutes of Health grant for three years. The grant was renewed when he moved to Duke.

A North Carolina family with a long history of intermarrying will be the subject of a special study this month by a group of 18 scientists. One scientist will be Dr. Raymond Massengill, director of medical speech pathology at Duke University Medical Center.

The family, which lives in two adjacent North Carolina counties, numbers between 4500 and 5000 persons. It came to the attention of public health authorities in 1956, when they noticed the prevalence of unusual eye ailments and spastic disorders in many family members. Since then, evidence of other diseases or disorders has been found, including cleft palates in 41 members.

Because of his knowledge of speech disorders and the cleft palate, Dr. Massengill has been asked by the National Institute of Dental Research to study the family population group.

He will study the facial deformities of these individuals and attempt to evaluate their speech, with particular emphasis on cleft palates.

Because of its many afflictions, the family has been somewhat isolated from the community until recent years when a public health nurse won their confidence. Since 1956, however, several studie have been done in an effort to better understand the hereditary biochemical processes that have caused the unusually high incidence of these diseases in this family.

Dr. Jane G. Elchlepp, assistant professor of pathology at Duke University Medical Center, has been named assistant dean for planning of education facilities, it was announced recently by R. Taylor Cole, university provost.

Though she will continue her teaching and research responsibilities as an assistant professor, Dr. Elchlepp will also be involved now in helping to plan future educational facilities at the medical

Dr. Elchlepp joined the Duke faculty in 1956. A native of St. Louis, Mo., she received an M.S. degree in zoology from the State University of Iowa in 1946, a Ph.D. in zoology from the same university in 1948, and an M.D. degree in 1955 from the University of Chicago.

A new teletype communications system at Duke

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AFFILIATED CLINICS

Bluefield Mental Health Center 525 Bland St., Bluefield, W. Va. David M. Wayne, M.D. Phone: 325-9159

Charleston Mental Health Center 1206 Quarrier Street, Charleston, W. Va. Malcolm G. MacAulay, M.D.

Phone: 344-3578

Beckley Mental Health Center 109 E. Main Street, Beckley, W. Va. W. E. Wilkinson, M.D. Phone: 253-8397

Mental Health Clinic Professional Building, Wise, Va. Pierce D. Nelson, M.D. Phone: 328-2211

University Medical Center Library is enabling students and researchers to find material faster than they could in the yellow pages.

The system, which went into operation in January, links three medical school libraries in North Carolina and two in Virginia.

Besides Duke, the five-link chain involves the University of North Carolina Health Affairs Library, Chapel Hill; Bowman Gray School of Medicine Library, Winston-Salem; the University of Virginia Medical Library, Charlottesville, and Medical College of Virginia Library, Richmond, Va.

The introduction of teletype communications at Duke is part of a program to improve communications between the medical libraries of North Carolina and Virginia. If necessary, it can be extended to other libraries on teletype hook-up in other parts of the country.

Dr. Albert Heyman, professor of neurology at Duke University Medical Center, has been awarded a \$55,000 grant for research in cerebral vascular disease.

The three-year grant, sponsored jointly by the United States Public Health Service and the Veterans' Administration, is designated specifically to help establish a research center at Duke and Durham Veterans' Hospital.

NORTH CAROLINA HEART ASSOCIATION

Dr. Carl W. Gottschalk, of Chapel Hill, has been named one of the ten recipients of the 1966 Awards for Distinguished Achievement in medicine given by *Modern Medicine* magazine.

Dr. Gottschalk is professor of medicine and physiology and American Heart Association Career Investigator at the University of North Carolina School of Medicine.

The awards are made annually to physicians and scientists who have made significant contributions to the medical profession. The winners are selected from nominations made by deans of medical schools, leaders of medical organizations and members of the *Modern Medicine* editorial board.

The Heart Association scientist received the award "in recognition of his ingenious creation of complex techniques leading to proof of the countercurrent mechanism in renal secretion." Dr. Gottschalk and the other winners are featured in a special January 3 awards issue of Modern Medicine.

AMERICAN COLLEGE OF RADIOLOGY

Drs. Edward S. Bivens of Albemarle and Everett H. Schultz, Jr., of Chapel Hill were among the 55 radiologists to become fellows of the American College of Radiology at the group's annual meeting in Chicago February 1-5.



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The College grants the degree of fellow to certified radiologists who have given distinguished service to their specialty over the years. Fewer than 1000 of the College's approximately 5600 members hold the degree of fellow.

Dr. Bivens was graduated from the Bowman Gray School of Medicine at Wake Forest College in 1946. He is now a member of the staffs of Stanly County Hospital in Albemarle and Montgomery Memorial Hospital in Troy.

Dr. Schultz, also a graduate of Bowman Gray School of Medicine, is a member of the staff of North Carolina Memorial Hospital in Chapel Hill.

THE NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN

The North Carolina Medical Retirement Savings Plan, a plan devised by the Medical Society of the State of North Carolina to allow members to take advantage of the Keogh Bill, began functioning in 1965. A number of physicians and their employees are now participating in this retirement provision program.

During 1965 many county societies had a program about the Plan presented by officers of Wachovia Bank & Trust Company and members of the Retirement Savings Plan Committee. These programs are available in 1966 to county medical societies.

Physicians desiring information on how to go about having their personal plan approved for participation in the North Carolina Medical Retirement Savings Plan may make their request to Wachovia Bank & Trust Company, Box 3099, Winston-Salem, N. C. 27102, trustee of the Plan.

NEW MEMBERS OF THE STATE SOCIETY

Dr. Henry Thomas Gunter, G, 303 S. Main St., Waynesville; Dr. Ernest Boyd Goodwin, Jr., G, Midway Medical Center, Canton, and Dr. Edgar Earl Marlowe, Jr., 1508 S. York, Gastonia.

AMERICAN ASSOCIATION OF BLOOD BANKS

For the first time, eight agencies have joined together in fostering the volunteer blood donor concept by endorsing the newly-released "Supply, Demand and Human Life" brochure developed by the American Association of Blood Banks' National Committee on Clearinghouse Program.

Joining in this national campaign to recruit additional volunteer blood donors are the American Association of Blood Banks, American Hospital Association, American Medical Association, American National Red Cross, Blue Cross Association, Health Insurance Council, National Association of Blue Shield Plans, and Public Health Service, U. S. Department of Health, Education and Welfare.

Demonstrating the need for this cooperative

effort was the shortage of blood which occurred as a result of the inability to make normal collections during the January transit strike in New York City. Only quick response to the call sent out across the country by the New York Blood Center and the AABB National Clearinghouse Office for blood of all types insured a supply to cope with the emergency situation.

The "Supply, Demand and Human Life" brochure was developed in recognition of the need for greater public information and donor motivation. Bernice M. Hemphill, treasurer of the American Association of Blood Banks and chairman of the National Committee on Clearinghouse Program, says the brochure presents a personal approach to reawaken people to the importance of making voluntary blood donations to meet the increasing demand for blood for surgical and medical cases.

To obtain copies of the brochure, write to the American Association of Blood Banks, Central Office, Suite 1322, 30 North Michigan, Chicago, Illinois 60602.

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

The National Association of Blue Shield Plans announced recently that it would sponsor the 1966 Norman A. Welch, M.D., Memorial Award program.

The award will be made to the author of the most scholarly and meritorious contribution to the literature of medical economics between July 1, 1965 and June 30, 1966. The contribution can be an article or series of articles, a book, or a published or delivered speech.

Literature to be judged will be compiled by the library of the National Association of Blue Shield Plans. Authors may submit entries by sending them to: Library, National Association of Blue Shield Plans, 425 North Michigan Avenue, Chicago, Illinois 60611. Deadline for entries is September 1.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Nineteen research papers on molecular and chromosomal biology have been published as a monograph, recording the proceedings of a symposium held at Buenos Aires, Argentina, in late 1964. The 354-page monograph, "International Symposium on Genes and Chromosomes—Structure and Function," is No. 18 in a series by the National Cancer Institute, National Institutes of Health, Public Health Service, U. S. Department of Health, Education, and Welfare.

The monograph is available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. The single copy price is \$3.50.

The Month In Washington

President Johnson has put a price tag of about \$4.5 billion on his fiscal 1967 health programs, both domestic and international.

The President's fiscal 1967 budget, for the year beginning next July 1, calls for spending about \$4.3 billion on domestic health programs under the Department of Health, Education, and Welfare. Cost of medicare benefits will be in addition to this total because they will be paid for by Social Security taxes.

Spending on domestic health programs would have been greater if some—such as the new heart disease, cancer, and stroke program—had not been cut back because of increased costs of the Vietnam war. The cutbacks mainly were effected by requesting smaller appropriations than Congress had approved. The appropriation requested for the heart disease, cancer, and stroke program was only half of the \$90 million authorized by Congress.

Johnson told Congress he would submit international health legislation to:

- —create an International Career Service in Health;
- —help meet health manpower needs in developing nations;
 - -combat malnutrition:
 - -control and eradicate disease:
- —cooperate in worldwide efforts to deal with population problems.

Johnson said the United States must be prepared to help developing countries that ask for aid in controlling population expansion. He said:

". . . population growth now consumes about two-thirds of economic growth in the less-developed world. As death rates are steadily driven down, the individual miracle of birth becomes a collective tragedy of want."

Two federal reports—by the President's Council of Economic Advisers and the Social Security Administration—covered medical costs and overall national spending for health care.

From the Washington Office of the American Medical Association.

The annual report of the economic council conceded that the "true" increase in medical costs may have been less than the dollar increase. The report said:

"In the most recent five years, medical costs have risen less rapidly than during the 1950s. This has been due primarily to the fact that prices of prescriptions and drugs have been declining. Also, the increase in charges for medical services—including doctors' and dentists' fees, eye examinations and eyeglasses, and hospital rates—has slowed down in comparison with the earlier period.

"The higher hospital and doctor charges reflected in the consumer price index may overstate the true increase in the cost of medical care when account is taken of the rising effectiveness of the care received. With the dramatic improvements in medical technology that have taken place over the postwar period, many patients get more real "services" from each day's stay in the hospital, or each visit to the doctor, than before."

The Social Security Administration reported that the nation spent \$36.8 billion in 1964 for health care, almost tripling the \$12.9 billion spent in 1950. Per capita expenditures more than doubled in the 15 year period, rising from \$84 to \$191 per person.

Over 90% of the expenditures were for health services and supplies. The balance was spent for medical research and construction of medical facilities.

There was a considerable shift in method of payment for personal health services from direct out-of-pocket payments to third-party payments. Payments by third parties which include insurance benefits, government payments and philanthropic payments, met slightly over one-third of the personal health care expenditures in 1950 and almost half of these expenditures in 1964.

Government payments continued to provide about 22% of the funds for all personal health services.

The Justice Department has ordered coordination of federal procedures to assure that medical facilities and institutions of higher learning which receive government funds do not practice racial discrimination.

The Department of Health, Education and Welfare was assigned the main responsibilities, including:

- —Preparing and distributing a compliance form to be submitted by all medical facilities and institutions of higher learning which receive federal money, and evaluating the submitted forms.
- —Conducting periodic reviews of recipients and investigating any discrimination complaints against them.
- —Attempting to secure voluntary compliance and notifying other departments and agencies when any such effort fails.

Both the American Medical Association and the Food and Drug Administration have warned the public against interpreting the acquittal of the promoters of krebiozen as meaning it is effective in the treatment of cancer.

A federal court jury in Chicago found the promoters not guilty of fraud.

"The results of a criminal proceeding should not be interpreted as establishing efficacy of the alleged new drug called krebiozen by its promoters," the AMA said. Cancer sufferers should consult with their physicians and not try to determine for themselves what is the best course of treatment in their own individual cases."

"As far back as 1963, krebiozen was proved to be nothing more than mineral oil and creatine, a common laboratory chemical," the FDA said. "That scientific judgment still stands. The FDA will carry out its responsibility to the public by doing whatever will be necessary to keep krebiozen out of interstate commerce. We will do this as a life-saving activity. Each day a person with treatable cancer relies upon krebiozen is a day that brings him closer to death."

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In Memoriam

Dr. Charles Albert Hensley

Dr. Charles A. Hensley, 72, a well known and outstanding Asheville physician, died April 10, 1965, en route to a Houston, Texas, hospital, where he was to undergo vascular surgery. He was stricken with a dissecting aneurysm during the morning while making rounds at the Aston Park Hospital, and was immediately flown to Texas, but died in flight.

Dr. Hensley was a native North Carolinian, having been born in Burnsville, a son of the late B. S. and Ruth Gardner Wilson Hensley. He studied at the Yancey Collegiate Institute and Wake Forest College, receiving his M.D. degree from Jefferson Medical College in 1917.

He served two years in Europe as a regimental surgeon in the United States Army during World War I.

From 1919 to 1925 he practiced general medicine in Barnwell, S. C. He moved to Asheville in 1926 and had been practicing internal medicine here for the past 40 years. He was a member of the Biltmore Forest Country Club.

Dr. Hensley was a member of the staffs of Memorial Mission, St. Joseph's, and Aston Park hospitals; the Buncombe County and North Carolina State medical societies, and the American Medical Association. He has served as vice-president and president of the Tri-State Medical Society, and in 1952 was president of the Buncombe County Medical Society.

He was an ardent fisherman, hunter, and gardener, and one of the charter members of the Siniard Creek Rod and Gun Club. He loved the out-of-doors and spent much of his spare time in the woods and lakes about Asheville. Those who enjoyed his companionship over the years will miss his congenial manner and true friendship.

Dr. Hensley was highly regarded as a physician among the medical profession and greatly loved by his patients and associates. His love for people was manifested by his gentle and patient manner for which he was noted. He will be greatly missed by his colleagues, friends, and patients.

He is survived by the widow, Mrs. Helen Tudor Stuart Hensley; two daughters, Mrs. Joshua Fry Bullitt Camblos of Asheville and Mrs. Gilbert Hume Woodward of Washington, D. C.; a halfbrother, Oscar Hensley of Asheville, and five grandchildren.

Resolved that the report of this committee be adopted and entered into the records of the Buncombe County Medical Society and that a copy be sent to his family, the North Carolina and American Medical Associations.

Buncombe County Medical Society

Frank Sabiston, M.D.

WHEREAS, The Lenoir-Greene-Jones Counties Medical Society was deeply saddened by the death of Dr. Frank Sabiston, one of its most devoted and loyal members, on June 17, 1965; and

WHEREAS, a great void was created in this community in the loss of this dedicated, soft spoken, gentlest of physicians who becalmed the most troubled waters with his quiet presence wherever he served, imparting courage to those who suffered and quickening hope in hearts that were faint; and

WHEREAS, this community also lost a servant in many areas of public service far beyond the bounds of his chosen profession, lending his thoughtful and wise counsel for all those who would benefit; and

WHEREAS, this membership has lost one of its most beloved and faithful friends, who through his service to the sick has brought by this reflection further esteem to our profession and Society; be it

Resolved, That this expression of our deep affection be recorded forever more in the minutes of the Lenoir-Greene-Jones Counties Medical Society, and that a copy of this resolution be sent to the North Carolina State Medical Society and to his family.

Roy C. Tatum, M.D.

North Carolina has lost one of its finest and most widely respected general practitioners of medicine in the death of Dr. Roy C. Tatum of Taylorsville on January 19, 1966.

Dr. Taylor died of heart disease while examining a patient in his office at Taylorsville, where he had practiced since 1945. During this time he saw the establishment of a community hospital which owed its very being in large part to his energetic promotion, and which continued to develop with his loyal support.

He was a champion of cooperation among doctors. Always interested in public affairs, he was forthright and honest in his criticisms. These were tempered with a unique sense of humor and a characteristic wit, so that they found their mark without offense.

In addition to his private practice, he pursued the often frustrating duties of county physician, and was one of the first in the state to organize a medical review board to advise the local Welfare Department on medical indications for granting public assistance. His increasing contacts with the poor and aging led to a great many off-therecord kindnesses, the full extent of which will never be known. His last few years saw him almost consumed by the unrealized dream of a nursing home to be built in connection with the local hospital.

Born in Davie County in 1890, he spent most of his life in North Carolina. He received a B.S. degree at Mars Hill College in 1916 and his M.A. degree in 1917. After working for the State Board of Health for a year, he entered Jefferson Medical College where he graduated with an M.D. degree in 1919. He began the practice of medicine in Erwin, N. C., where he was married to Miss Helen Adams. The next year he moved to Statesville, where he practiced until 1933. He then began his active army career by serving as medical officer at a number of CCC camps. He also recruited physicians for the Army, and finally served as second in command in the hospital at Fort Bragg until 1945, at which time he held the rank of colonel.

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In spite of the spectacular drugs and techniques science has discovered in recent years, blood remains the best wonder medicine—as whole blood, as plasma, as any of the many parts that scientists now can draw from it.

In "Blood—New Uses for Saving Lives," Michael H. K. Irwin, M.D., surveys the advances of the past 25 years in understanding and using the "magic gift of life." This new Public Affairs Pamphlet is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N. Y. 10016.

Because blood cannot be made synthetically, its preservation and use to the fullest are of vital importance. Whole blood, which must be used within three weeks, is used in hemorrhage cases, anemia, injury-caused shock, blood diseases, surgery. But even if blood is not used within three weeks, if it contains clots, or if it is obtained from donors who have suffered from malaria or infectious hepatitis, it can still be used as plasma or plasma proteins.

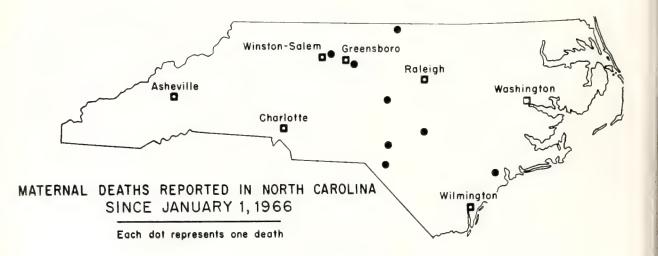
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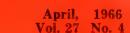
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Billing Hospital Patients for Radiologic Services

Freedom of Choice and Three Alternatives

ROBERT R. CADMUS, M.D.*

Chapel Hill

Although I shall obviously discuss the subject of billing hospitalized patients for radiological services from the viewpoint of a medical administrator, since it is in this role that I have been invited, permit me for a moment to look at this task as if I were an ophthalmologist. Certainly, I would not attempt either to diagnose or to treat you as a group. Rather, I would examine each of you individually and check your vision against the accepted 20/20 standard. As a result, many of you would be classified as myopic or hypermetropic and some even astigmatic, Consequently, no single pair of glasses could be expected to correct the vision of each individual. Furthermore, I would treat you according to currently accepted techniques, yet knowing full well that tomorrow might bring new knowledge which could cause me to alter my plan of action.

Similarly, in the matter of billing hospitalized patients for radiologic services, there probably are individuals in this room with every conceivable point of view. But unlike 20/20 vision, there is no such standard which would automatically classify you as either normal or abnormal, since no one viewpoint is universally accepted as completely "right," and likewise no one position is considered absolutely "wrong." Within the accepted limitations of law and ethics, one's viewpoint on this debatable subject is a matter of judgment—a matter of values

and with the acquisition of new knowledge each of us might properly change our opinions. Therefore, I plan neither to placate nor to criticize you, but rather try to help you determine and define the essential values, so that, as with a well-written optical prescription, each of you may be able to see things a bit more clearly.

For editorial comment see page 211

Basic to this discussion of the relationship between radiologists and hospitals is the direction of outlook; that is, where does one put his heart? Is it in the furtherance of organized radiology; is it in the patient's interest-not as he interprets it, but as the patient sees it; is it in fostering one particular method of reimbursement; or is it in some other direction? I am sure that some of you will jump to the conclusion that radiologists blend all of these values in their professional dedication; yet I am not quite sure that our field of vision is wide enough to look in all of these directions at the same time. In fact, some appear, at least in part, to be incompatible with others.

Yet none of these choices is bad, or even unprofessional. All are quite legal, all are quite honorable, all fit within a democratic society, and all are practical and reasonable within a given set of circumstances.

So what is the problem? Why do we apparently have difficulties? Why are hospitals and radiologists often thought of as natural enemies? The answer is rather simple but often overlooked. While these choices of action are available to you as

^{*} Read before the N. C. Radiological Society, Southern Pines, February 19, 1966.

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radiologists, so are similar choices available to all other individuals and groups in a democracy—even to hospitals. If two mutually involved parties happen to make the same choice so that there is no incompatibility—fine; there is no problem. Or if by chance an individual's decision involves no one else—again fine; there is still no problem. However, if two parties, particularly two parties involved in a close interdependent relationship such as that which exists in a hospital, choose to follow different paths—paths which may not be compatible—then conflict is inevitable.

Under such circumstances there are only three possible choices: (1) One party surrenders to the other; (2) each party goes his separate way; or (3) a compromise is negotiated.

Compromise?

Although we all know of happy, but rare, examples of the first two, I think the third alternative—that of compromise—offers the most promise of success. It is the normal pathway by which reasonable and mature men settle their differences. However, compromise appears to be a dirty word to some administrators and to some physicians as well. At times, I feel it is even a dirty word to the American Medical Association. As you may know, the AMA's House of Delegates recently adopted eight statements, one of which supported the philosophy of freedom of choice. This particular item stated: "The AMA opposes any program of dictation, interference, or coercion . . . affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medica care to patients under Public Law 89-97 (Medicare) or other third party plans." 1 am sympathetic with the intent of this statement, but can there really be "freedom of choice of the physician to determine for himself" his financial arrangements with third parties or, under the law of alternatives, must he always negotiate such arrangements? Likewise, the American College of Radiology has decided what it thinks is right in regard to patient billings and would hope that hospitals would be willing to surrender their point of view.

Remember, I did not say that either plan of action is wrong. I merely said that when two parties sincerely disagree, there are only three alternatives: surrender unilaterally, part company, or compromise.

Much of our present difficulty appears to me, at least, to have its roots in our failure to understand and accept this complex concept of freedom of choice. In blunt terms, the decision as to how hospitalized patients will be billed for radiological services cannot be decided in this room or, for that matter, by your state or national society, by the AMA, by hospital administrators or their state and national organizations, by the Social Security Administration, or even by the patients themselves. It must be a joint decision made by the mutual consent of all parties concerned.

Unilateral action?

Of course, if you prefer the privilege of unilateral action, two of the three previously listed choices are still open to you. You may surrender your principles, which is not only unlikely but also not particularly reasonable unless the offer meets your legitimate needs; or you may choose to go it alone, which creates another whole set of problems.

A strong and perhaps militant united front such as that being pitted against the Social Security Administration, particularly by the College of American Pathologists, might be effective. After all, the principles to be followed in reimbursing hospital-based physicians for services provided under the Medicare program as laid down by the Commissioner of Social Security, Mr. Robert Ball, may be lawfully challenged by anyone holding a contrary point of view. And who knows? The pathologists may even be right in believing that Mr. Ball's regulations go beyond the intent of the law or even contrary to it. Certainly, in a democratic society no thinking person would want to stop such expressions of free speech. However,

one might hope that both sides would wish to evaluate the alternatives. Perhaps uncompromising rigidity is not the way to solve disputes.

But if I had to guess, I would say that these pressures on the Federal Government are not going to be very effective. First of all, they already represent a compromise. Secondly, I would dare say that if the late Mike Quill couldn't bring New York to its knees, one's chances of bringing the Social Administration, hospitals, Security patients to theirs are pretty slim. This is particularly so since the general public is even less tolerant of the demands of doctors than of the demands of unions, and more importantly, I believe there are more cracks in your solidarity than there ever were in Quill's. By this I mean that there appear to be many physicians-hospital-based specialists included-who are not convinced that any one economic system is good for all physicians under all circumstances, and who actively resent any suggestion that they do not have the freedom to chose the economic -not ethical, but economic-arrangement best suited to their needs.

Therefore, those hospital-based specialists who are unhappy about some feature of their arrangements with their hospital or hospitals, have little choice but to go to the bargaining table. Frankly, unless you know something I don't know, you have neither the constitutional right nor the power to do otherwise. And you will probably have to negotiate individually, not "industry wide," for the simple reason that there is no legally constituted spokesman for all hospitals. Even the Social Security Administration refused to accept that role. They have said: "It is not the function of the health insurance program to determine the arrangements which a hospital and a hospital-based physician enter into for the compensation of the physician."2 Mr. Blumenthal of HEW reaffirmed this position at the American College of Radiology Workshop on Medicare and Billing held in Chicago last December 3. Your group may properly press for some uniform conditions, but unless the rules are changed, the decisions will have to be hammered out one hospital at a time.

Self-Interest

Now, whenever one goes into a negotiating session, it is not unreasonable to act somewhat selfishly; that is, to try to get concessions favorable to your point of view. But the problem is, what is "selfish"? All that glitters, remember, is not gold, and often what appears to be selfish in the short run is disadvantageous in the long run. I think Part B of Medicare illustrates this point, at least to a degree. Certainly, some of the first blush of that victory, at least in some physicians' eyes, has faded, and instead of freeing the shackles of the hospital-based specialist, we now see restrictions where there were none before. As an example, we need only be reminded that a physician, at least for in-hospital Medicare patients, can charge only for services he "personally" renders; or that if a hospital and a radiologist fail to agree on the allocation of charges, the insurance carriers are privileged to resolve the issue "by negotiation if possible, otherwise by time studies or other suitable methods."3 These are new rulings which may cause some to ask if the apparent short-range gain was, in fact, a long-range loss.

In making this evaluation of selfishness, I somehow believe that whatever is best for patients will automatically end up best for physicians, radiologists included. Remember, patients are not unlike that musical vixen Lola—and what Lola wanted, Lola got. Consequently, any decision as to how patients are going to transfer money from their pockets into yours is going to be their concern, and they will not only want to be in on the discussions but will act just a little like Lola—and probably with the same results.

With the growth of third-party payers, these many users of hospitals have found a strong and well informed ally, and in the case of the independent consumer, hospitals themselves attempt to be their spokesman, since trustees are just that—individuals entrusted to operate institutions in the public interest. For this devotion society has granted them tax-exempt status and other protective immunities. The public has not

seen fit, on the other hand, to extend these advantages to individual physicians operating outside of the non-profit shelter in spite of equal dedication to patient care, and a remarkable similarity of endeavor. Furthermore, few courts or attorneys-general are now tripping over the confusing differences between the practice of medicine—which to be sure is a licensed profession—and the delivery of health care—which is a team effort, often accomplished within the corporate structure of a hospital.

Therefore, since it appears that there are, at least in some people's minds, two legitimate points of view concerning the billing of patients for radiologic services, and since the positions can't be reconciled unilaterally, I see no other way to settle the problem than to negotiate. I do not want to endow any unsavory union-management connotation to this word "negotiate," but obviously the basic principles are the same. Rather, let us for this discussion compare these necessary sessions to the Ecumenical Conference, because even at the Vatican there was division of opinion and need to compromise.

What Radiologists Want

Now, how does one go about sitting down and negotiating? From what little I know about your contracts, you are masters of the art, but to make sure we don't misunderstand each other, let me mention a few details. First, you must determine your demands, not in generalities, but in specific terms. What are your demands? Let me list those which I hear most frequently, recognizing, of course, that this is a composite list and therefore some points are inconsistent with others. They would be as follows:

- 1. Privilege to lease and operate the entire department as a private enterprise, reimbursing the hospital as the American College of Radiologists says "on a dollar per square foot basis as are leases in medical arts buildings,"
- 2. Privilege to bill patients separately for your services with or without a hospitalapproved fee schedule or a system of relative values.

- 3. Privilege to have the hospital bill for your services with or without using your name, and with or without a handling charge.
- 4. Privilege to have your salary increased, your percentage raised, or otherwise to get a better deal, considering particularly your age, skill, risks, and the laws of supply and demand.
- 5. To have adequate, modern, and serviceable equipment with which to work, and ample consumable supplies.
- 6. To have adequate space in which to work.
- 7. To have some control over the number and selection of departmental personnel and other budgetary matters.
- 8. To have freedom, as a member of the medical staff, in matters of professional judgment.
- 9. To enjoy certain fringe benefits, which might include paid holidays and vacations, time off for professional meetings, reimbursement for the cost of educational programs, paid insurance, dues, journals, and other employee benefits.
- 10. To have some arrangement whereby the more you work, the more you earn, but in the reverse situation, a guaranteed minimum.
- 11. To have some protection from unfair competition, such as exclusion of open staff arrangements whereby the choice of radiologist is determined by the patient or by the referring physician or even worse, having each physician read his own films if he so desires.
- 12. To have reasonable job security with sufficient tenure for adequate personal planning.

I am sure you could add other demands or subdivide some of those I have listed for greater clarity, but I think they adequately make the point.

What the Hospitals Want

Now what are the points the hospital might consider as they go to the negotiating table? Actually, I think their list is shorter but perhaps more comprehensive. They are as follows:

1. To have one professionally competent

individual responsible for the radiologic diagnosis and treatment of patients, and for all the supervision of the department, including the selection of assistant radiologists, the control of technical and clerical personnel, the maintenance of high standards—professional as well as administrative, the care of indigents, and the operation of all educational programs.

- 2. To have an organizational arrangement acceptable to the entire medical staff with respect to the availability and adequacy of service and to the charges made to their patients.
- 3. To have sufficient control over the costs and charges within the radiology department so that neither patients, other members of the medical staff, third-party agencies, the general public, nor the courts could so criticize as to jeopardize its coveted voluntary system of tax-exempt operation.
- 4. An adequate, break-even financial return which, of course, would be sufficient to cover direct costs, departmental overhead, and a fair share of the non-income producing institutional overhead—an arrangement not unlike what the NIH now pays universities for research and what most third-party payers of all types consider equitable. Definition of terms, of course, must be mutually understood.
- 5. Reasonable requests regarding needs for space, equipment, and personnel.
- 6. And finally, a radiologist who will fit in—whatever that may be interpreted to mean.

Points of Issue

Looking over these two lists, one finds relatively few points of issue. When I was first invited to join your meeting, I felt that my task would not include such a listing, but rather would be to interpret how you and the hospitals were going to handle Medicare billings, because it was believed that it had to be done by you as individuals. Now we know that Medicare has side-stepped that issue and, against organized medicine's wishes, has returned it to local option. To be sure, costs of hospital care will have to be charged to funds available under Part A,

and costs of professional care charged to funds available under Part B. This is the way the law reads. However, in this matter of separation, the government is only concerned with how the charges are sent into Washington, not how the return payments are distributed in your own home town.

Therefore, I have focused my remarks, not on the mechanics of a whole new federally inspired system, but rather on the upcoming need to make minor adjustments in your present arrangements. Actually, I would expect little need for major renegotiations—merely a constructive change in bookkeeping. At least, that's what some of the radiologists in Tennessee now think, men who apparently originally demanded that all contracts be renegotiated by April,4 in accordance with what they hopefully thought Medicare was going to require. The Wisconsin Radiological Society adopted a resolution requiring its members to be billing directly by next July, yet one report indicates that many of their radiologists now do not want such a change. 4 I frankly hope you will not make any unilateral decisions which will put you among those societies which had to eat their words.

But fear not; you have still won a great victory. For years radiologists have properly urged hospitals to bring their charges in line with actual costs—to stop making money from radiology and the laboratory. That day has now arrived. The Social Security Administration has said that "hospitals and hospital-based physicians will be required to keep records and be prepared to furnish information which can substantiate the agreements they enter into with respect to the allocation of the compensation of physicians."2 And as I said earlier, if hospitals and radiologists can't agree, the carrier can come in and settle it. These are your weapons! Actually, I don't believe Medicare actually forces good cost-accounting, but it does force intelligent allocation of charges. Although not technically the same, the two are closely related.

Costs and Charges

Frankly, in your negotiations I would hope you would demand that the total costs

of operating the radiology department, minus any professional reimbursement, be determined first and mutually accepted. Next, a system of charges should be developed which, considering the anticipated work load, bad debts, reserves and other contingencies, will bring in the necessary income to balance the expenses. I would hope your administrator would have already done this, but I appreciate that the stimulus has not always been as strong as it is now, and that not until recently has he had the help of such programs as the Hospital Administrative Services of the American Hospital Association.

Determination of Fees

Next, your fee has to be determined. Here, two principles laid down by the Social Security Administration come into play. The first states that the professional component of any charge must be for "an identifiable service requiring performance by a physician in person"; and secondly, "no escalation of total costs to the patients and the government" will be permitted.2 These same principles state, however, that the amount allocated for professional services "may be based on a schedule of relative values, on a uniform percentage of the charges made by the hospital or the physician to other patients for both professional and supporting components of the service, or on another method approved by the carrier as equitable."2 Consequently, the chances are that your present arrangement of reimbursement will be satisfactory to Medicare. If it is unsatisfactory to you, however, that is a different problem. In any event, some method must be developed for determining the professional portion of the total charge for radiology.

One could ask why physicians' fees should enter the negotiations, and I will try to answer that in a moment. But first let me say that the method you choose will determine the mechanics by which you develop the professional portion. I think it inappropriate here to go into all these variations. Suffice it to say that the method developed should produce a reasonable income;

but remember, as circumstances change, so should the charge and its allocation change. As you know, departmental supervision goes into the hospital's portion.

Once a charge schedule has been made, I care little whether it is billed by the hospital or the radiologist. Under either system, some identification of the individual rendering the service will be required, not for the reasons usually voiced, but in order for computers to determine and report the "reasonableness" of incomes derived from "reasonable" charges. Certainly, this key decision in billing should be made not on present circumstances or on what convictions either you or the hospital might have, but on what the future holds. After all, there are some discernible trends.

Incidentally, I see no justification for two parallel systems of billing, one for Medicare and one for all other patients; neither does the government. The most talented public relations specialist couldn't possibly persuade patients that when they are under 65 one method of billing is in their best interest, but when they reach 65 some mysterious economic force makes another method of billing more economical for them and their government. Therefore, I would urge you to seek one method suitable for all patients—young and old, rich and poor.

Third Party Payments

Returning to the matter of joint or separate billings, let me put it this way. In the near future everybody will have his basic hospital and professional bills paid for him. The aged—and eventually the disabled, the unemployed, and the otherwise disadvantaged individual—will probably have his health care expenses paid from tax sources. The employed sector of our economy and their dependents will have their hospitalization and medical care provided through employer-paid benefits and administered by a non-governmental insurance system. Everyone will be entitled to basic health care, but few, if any, will pay for such care out of their own pockets at the time of illness. Therefore, few will be concerned whether their bills arrive at the insurance

office in one or two envelopes or with or without a physician's name. Patients will have-and most of them already haveonly one understandably selfish thought: their own well-being. Their participation in the payment for their own care will be limited to showing an identification card. Therefore little teaching of the public about the differences between hospital and professional services will come about by separate billings, even with the use of the instructional slip which the American College of Radiology has suggested be given to the patient as a bill stuffer. Supplemental benefits, by the way, will merely tag along, and will never become a tail that will wag the dog.

Therefore, your image in the patient's eyes will be created by your sympathy and your skill, not by your name on a bill. Your image in the eyes of third-party payers will depend on the reasonableness of your fees and the amenities which you offer in the completion of the necessary paper work. Although your professional associates in internal medicine. surgery, and other branches of medical practice may follow this path more slowly, it won't be very long before the bulk of their income will also come from third parties, not patients' pockets. The often repeated cliche about wanting to be like the surgeons may soon have an empty ring. Talk it over with a busy orthopedist and ask how much of his income already comes from third parties.

Fee schedules, although curently maligned, seem inevitable in the future, but hopefully there may be flexibility, intelligent administration, and adequacy in respect to reimbursement. Since a fee schedule is the only way insurance actuaries can set premiums, and since the bulk of benefits will come from premiums, fee schedules seem unavoidable—like it or not. As you know, P.L. 89-97 (Medicare) permits physicians to charge patients directly, after which the patient can then send the receipted or unreceipted bill to a designated carrier for reimbursement—whole or in part—depending upon the fee and whether it was for an inpatient or outpatient service. If the fee schedules are, in fact, synonomous with prevailing fees, there wil be little incentive to use this system considering the patient's almost certain negative reaction. If, however, fees are "unreasonable," this may be the escape route many doctors will use. We should wait until these details are promulgated by the SSA before any course of action is determined.

Consequently, if you temporarily want to bill patients separately with your name on the bill, but, of course, according to a hospital-approved charge schedule, that's all right; but frankly I look at it as a concession to your happiness-not holding the line for democracy, because democracy doesn't want it held there even if you do. But if you do adopt this system temporarily. be prepared to make it more rational when the percentage of third-party payments nears 100% and few, if any, of your patients will ever see the hospital-physician allocation of fees. Meanwhile, polish your image by providing exemplary patient care and gentle service, not by trite phrases and slogans which only make the sophisticated user of your service snicker and sneer.

The Hospital's Concern

Now, let me return to the question of why the fees of the hospital-based physician are of concern to the hospital. This question is generic to a host of tangential issues. Why are radiologists treated differently from surgeons in this matter of billing? Isn't it unethical to sell one's services to a lay corporation? A percentage contract is fee-splitting. Radiology is the practice of medicine—not a technical service. Obviously, in each of these points there is either an element of truth or enough substance to justify the question. This makes an answer difficult, and in fact the stock replies of monopoly, service to other physicians, hospital-based, and similar arguments have miserably failed to win any converts over the past 20 years. Obviously, if you accept my concept of the freedom of choice and the three alternatives, this could suffice as an answer-hospitals want to be concerned. And although that does not make it either right or wrong, it does make it a fact.

But I should like to try to offer a new reason why hospitals are concerned with your professional fee-an answer which might find some shred of acceptance. It is rooted in a concept of medical economics not yet well verbalized but, I believe, sound. I indicated earlier that it is a growing national policy that no person shall be denied medical care because of low income. Because of the unevenness of illness, both in frequency and in severity, the insurance principle of spreading costs—a product of free enterprise—is the only sound way to guarantee this promise. Furthermore, I believe we are seeing as national policy, not a federally controlled system of medical care, as in England, but a system of insurance government-funded for the aged, the nonproductive, and employer or consumer paid for the vast majority of the employed or self-employed and their families. There is no question that the operation and responsibility for the control of the federally funded segment of our population—presently Medicare—has largely been passed down to the so-called fiscal intermediaries for Part A (the hospital portion) and insurance carriers for Part B (the professional fee portion). These are creatures of the civilian economy, not of federal bureaucracy. These fiscal agents, in turn, will pass much of their responsibility for control down to the individual providers of service. Therefore, the voluntary system is being tested and is being given its last chance to "put up or shut up."

The insurance industry, for one, doesn't want to see this system of non-governmental intermediaries fail, and they see uncontrolled costs as the greatest threat. Consequently, the pressures will be on for hospitals to remain "reasonable," and the same goes for physicians. Insurance companies feel they already have some control over the hospital-based physicians. How history brought this situation about matters little. However, because of it, the expenditures for the services of the hospital-based physician can, in general, be accurately estimated; and since, at least under Medi-

care, they can't be increased by virtue of the legislation alone, some fiscal stability is assured. Therefore, the insurance industry sees itself—not doctors—on the front line for the defense of the voluntary system, and it is going to react violently to any action, whether from hospitals or radiologists, which would throw the case open to charges of lack of public interest—and unreasonable costs already have become synonomous with lack of public interest.

Therefore, hospital trustees, with the insurance carriers on their backs, are not, in my opinion, going to say that professional fees are none of their business. They too feel a sense of dedication to the public interest, and I don't think they will expose themselves to the criticism of providing the space, facilities, and personnel for an essential part of hospital care and, at the same time, of ignoring the financial return the use of those same facilities would bring to the radiologist. I know this is inconsistent with their present relations with the surgeons, but as I said earlier, when a greater percentage of professional fees come under some third-party system, the surgeons will move closer to your present situation. At that point, I predict, hospitals will loosen up a bit and transfer some of their present control of hospital-based specialists to the carriers under which all physicians will be treated equally, but also controlled equally. In effect, this will bring about the transfer of professional fees from Blue Cross into Blue Shield, a goal for which you have been striving for years. At that point, separate billings will be more readily acceptable; however, they won't go to patients, but to fiscal agents, and you may then be glad to have somebody collect your money for you.

Legal Implications

But there is one further reason why financial arrangements between physicians and hospitals get lumped together, and that is because they are getting lumped together in the eyes of the law. The recent Darling vs. Charleston Community Hospital court decision⁵ is a case in point. As you may know, this was a suit, upheld by the

Supreme Court of Illinois, which held the hospital liable for the loss of a college football player's leg because the physician in charge—the doctor on emergency call at the time—applied a cast too tightly. The court quoted a New York case as follows:

"The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to produce them to act upon their own responsibility, no longer reflects the facts. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment."

The court further recognized that the enforcement of accreditation and of adequate medical staff bylaws would have forced this physician to seek a consultation, particularly after complications had developed, and therefore the failure to enforce these standards of care was the hospital's responsibility, not that of the individual physician treating the patient. Can you visualize a group of trustees with this threat over their head—owning the radiologic equipment and liable for any negligence surrounding its use, employing the technical personnel and, therefore, responsible for their actions as well as yours, and having, because of Medicare, to allocate costs between the hospital and the physician, agreeing to retain this heavy responsibility and, at the same time, give up all interest in what it is going to cost the patient to use their facilities? Maybe they should, but I don't think they will.

Lease Arrangements

I think some of my remarks have alluded to my feelings that in your negotiations with hospitals, little progress will be made on demands for a lease arrangement. Such a system seems so much against current trends, although, frankly, it is mentioned as a possibility in the federal principles. Obviously, 40 radiologists in Idaho do not agree with me since they have "issued a joint ultimatum that demanded lease arrangements with hospitals at the earliest possible date." However, I don't think the climate for such a possibility exists in North Carolina. In fact, it has been reported that in

some 30 states, including North Carolina, voluntary hospitals may risk loss of all or part of their exemption from real estate taxes if they lease facilities for another's profit.

Toward a Mature Decision

As I said at the very beginning, I have no one lens which will be satisfactory to each of you. I don't really expect you to give up your convictions on my say so. I have tried to present certain points of view, however, which might help mature your thinking, so that in time, you may make a decision with which you will be pleased year after year.

As we face the future, let's not look backward and drag up all the threadbare arguments we've heard and used so long. During the past year both hospitals and physicians testified before the people's representatives in Congress on an issue close to the heart of every American—the cost of health care, particularly for the aged. Every stop was pulled and eventually Congress spoke. Certainly, changes in the law will be made, but it will not be repealed. We will merely see administrative refinements and perhaps an extension of benefits.

Yet, with or without Medicare, there has been an itch, a dissatisfaction common to many radiologists which some have called ethical, others economic.

Although I do not intend to tell you what is right or wrong, or how to stop this itch. I do say I see trends which, like ocean waves, shouting or resolutions will not hold back. I urge you to look at the future and then make decisions to meet that future. I do not see anything in Medicare or in your relationships with hospitals that you need really fear. Certainly, things will be different. The public wants them different, but you will have a profession; there will be a market for the practice of that profession: you will be free to make professional judgements without interference; you will be an influential member of the medical staff; you will have job security, adequate compensation and many fringe benefits, and just about everything else that this life can offer.

If you settle for these, you will have a lot of people, including hospital administrators, pulling for you. Oh, yes, there might be exceptions, but let's not live our lives around these rarities.

If on the other hand, you push trustees and the public for things which they believe to be too much in your self-interest and too contrary to theirs, you may lose that coveted bargaining position you now enjoy.

I'm for you, I'm for radiologists, I'm for voluntary medicine. But, we have an up-hill fight. Every step taken must be in the right direction. We are seeing tremendous changes in health. The people want these changes. If something vital is wrong, let's stop it, but if it's in tune with the times, let's go along with it—mould it the best

way we can. We have a lot to gain if we do, and a lot to lose if we don't; and radiologists and hospitals will have to work as a team, not adversaries.

I think most administrators are ready to do their part. We hope you will join us.

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The Psychologic Management of Leukemic Children And Their Families

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A family crisis ensues when it is learned that one of its children has leukemia. The desire to ameliorate the shock has motivated many physicians to study both the children with this disease and their families. Since there are currently no methods of cure or prevention, efforts have recently been made to define the role of the physician and his associates in helping the family accept this tragedy with minimal trauma.¹⁻⁹

To evaluate the management of leukemic patients and their families at North Carolina Baptist Hospital, 15 interviews were held with parents of children who had died of leukemia. The interviews also provided an opportunity to look for regional pecu-

liarities that might require a different approach from that used in other localities. The interval between the child's death and the interview was greater in our cases than in other studies based on follow-up interviews, 6.7 and in all but two cases the child's home was visited personally, another departure from the usual method.

Material and Methods

The North Carolina Baptist Hospital, a 500-bed private hospital, is the major teaching facility for the Bowman Gray School of Medicine. There is a School of Nursing and a School of Pastoral Care. In the absence of

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a social service staff, the students and faculty of the School of Pastoral Care per-

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form some of the functions of social workers.

Selection of subjects

From a group of patients whom one of us (R.B.T.) had come to know during a three-year period as a fellow in hematology or as chief of pediatric hematology, there were 22 who met the following criteria: (1) had been diagnosed as having leukemia (or in one case, lymphosarcoma); (2) would have been dead at least 11 months at the time of interview; (3) had lived within a 100-mile radius of Winston-Salem.

Letters were written to the parents of these 22 children briefly outlining the project and requesting their participation. A self-addressed postal card was enclosed. Parents were asked to respond by marking one of three choices: (1) grant an interview in the home; (2) complete a questionnaire if the interview was objectionable; (3) decline to participate.

Seventeen families agreed to an interview, two letters were returned because of inadequate addresses, and no reply was received in three instances. One parent requested that he and his wife come to the medical school for the interview; another family volunteered to come. These offers were accepted; the other parents were seen in their homes. Two cooperating families were not visited because the pressures of the academic year did not allow enough time.

Characteristics of children and families

The patients included ten boys and five girls whose ages ranged from 10 months to 11 years 3 months at the onset of illness. All had received chemotherapy. The length of survival from diagnosis ranged from 3 to 25 months. In all but two cases the diagnosis was acute lymphocytic leukemia. One child had lymphosarcoma; the other, Down's syndrome and acute myelogenous leukemia.

There were three families with four children, two with three children, seven with two children, and three with only one child. Both children of one family were adopted.

The mothers' ages ranged from 19 to 27 years and the fathers' from 25 to 46 years.

One father had committed suicide a year prior to diagnosis. One father had been married prior to his present marriage. All other parents were living together and had been married only once.

One family was Roman Catholic, the others Protestant. All lived in Southwestern Virginia or Western North Carolina. All but one lived in rural areas or towns of less than 10,000 population. The other family lived in a city having a population of between 10,000 and 50,000.

None of the families were wealthy. Some of the parents had college degrees, but the majority were semi-skilled or unskilled workers. Commonly both parents worked.

Method of questioning

A questionnaire was prepared that included biographical data, recollections about the diagnosis, the course of the disease, and the death of the child. Parents were questioned about their activities since the child's death.

The authors visited 13 homes. We went together and conducted the interviews jointly. After introductions and greetings, the interview followed an outline covering points in the questionnaire. The visit lasted about 45 minutes.

Results

At this point it should be noted that many of the impressions and observations presented here were not recorded at the time of the events to which they relate. They depend upon what the parents were able to recall. Hamovitch⁷ noted in his study, however, that "selective recall" agreed well with observations recorded during the illness.

Feigel¹⁹ has discussed death as a taboo topic. The authors are aware that their own taboos and inhibitions were in operation during both the planning stages of the project and the actual interviews with the parents. In spite of these limitations, the data gathered seem worthy of presentation.

Initial reactions to diagnosis

The majority of the patients were re-

ferred to NCBH without a diagnosis, but the possibility of leukemia had been suggested to some families. A feeling of shock on learning the truth was universal. They could not believe the diagnosis; they hoped it was not true.

Although parents thought that there was no "good" way to reveal the diagnosis, only one parent was unhappy about the particular method used in her case. The family physician had told the father and paternal grandfather that he suspected leukemia, but told the mother that the child had infectious mononucleosis. That night, after the child had been placed in the local hospital, this mother confronted the doctor and asked bluntly, "Does my child have leukemia?" Honesty on the part of the referring physicina and the hematologist was generally considered to be of the utmost importance.

One family did not want to know the diagnosis. "Just tell us what to do; we'll do it." At the time of the interview they still remained reluctant to discuss the diagnosis.

One father, a justice of the peace, noted that he was not "normal" at the time of his son's illness. He resented authority if he thought it to be contrary to the best interest of his son. This man stated that he nearly assaulted a house officer because he, the father, disliked the other man's approach to his son.

Hospitalization

One of the parents, more often the mother, wanted to stay with the child at all times. Suggestions that parents could not remain with their children aroused violent reactions. Many parents were disturbed because the physical plant at NCBH was much older than that of their local hospital: mothers were accustomed to having a bed in the child's room. Not only were no beds available for mothers at NCBH, but the only accommodation for the parent was a straight-backed chair. Private rooms were not desired—"It helped to see other people."

A mother stated that at the time when her shock was greatest, she was a stranger in the medical center. She remembered being tired and hungry after the long ride from home and the hospital admission procedures. Yet directions to the cafeteria were so poorly given that it took her 30 minutes to find it.

One parent complained that rigid enforcement of visitor regulations caused important visitors such as pastors to be "run out" rudely in the midst of significant conversations.

The medical school teaching environment itself was a source of difficulty. At the time of the interview one family was still concerned about the "doctors in white." They could not understand why any physicians other than their private doctor had anything to do with their child. Other parents were aware of the medical school and its teaching methods but still had complaints. Several parents thought that two or three separate, complete physical examinations on return visits were unnecessary, particularly when the child was acutely ill. Mothers objected to giving the complete history to a third-year medical student or house officer on each return admission, especially if the admission was only for a transfusion.

The inconsiderate attitudes of one particular house officer and one nurse were mentioned by several families. In contrast, the interest of the student nurses was appreciated and praised.

The business office of the hospital drew criticisms from several parents. They complained that the bills were never correct. One parent remembered being called from the room of her dying child to discuss her account.

Clinic visits

The recollections of clinic visits were essentially positive. One family looked forward to the visit because it was hoped that the child would be helped. One technician who "did the sticking" was held in affectionate regard: "She had a way with children." The visits provided the parents with an opportunity to talk together. On the other hand, the trips were long and tiresome to a few. Others feared rehospitalization. The children dreaded the days when bonemarrow aspirations were done.

Home life

The home lives of these families were generally centered on the sick child. Both parents and siblings sacrificed time and money for the patient. Parents admitted that the other children were neglected during the illness.

One family reported that their children often came home from school with distressing questions prompted by their classmates (no doubt the result of conversations overheard at home). Frequent telephone calls from friends and relatives necessitated an unlisted phone number in at least one family. Others recalled that the many inquiries were tiresome.

Social events were not enjoyed. Parents "felt guilty" about being happy. One 19-year-old mother was disturbed at parties when someone would ask, "Aren't you the one whose child has leukemia?"

Problems and help

In additional to the emotional strain imposed by illness, these families were faced with such practical problems as finances. transportation, and the matter of running a household, often in the mother's absence. Every family but one had relatives nearby on whom they called for help with transportation and household tasks. Churches, civic funds, fellow employees, often helped financially. The one family with no near relatives happened to live the greatest distance from the medical center. For clinic visits a mother and a daughter rode the bus to Winston-Salem the day before and returned the day of the visit, leaving the other children in the home of a neighbor. Employers were felt to have been generous and considerate about working arrangements for both mothers and fathers.

Emotional help was sought and received from ministers; however, some parents emphatically pointed out that their minister was unable to function in this role. Some "talked it out" with friends. No one mentioned other members of the family as a source of emotional help. One mother received help from reading her Bible. Another family stated that daily devotions, begun early in marriage, were a source of strength. One father joined a church for the first time in his life during his child's illness; the degree of help received was questionable.

Death and mourning

Whether death occurred at home, in the local hospital, or at the medical center, the parents often recalled a sense of relief. One father remembered a chaplain's comment that God had given the family "a dirty deal" by letting their son die from leukemia. This was not the father's view, and it angered him.

Details of the mourning process were difficult to evaluate. All families reported a time of activity for several days after the death. Visitors and food were plentiful. This was followed by a variable period of loneliness and isolation as friends stopped coming. In one exceptional case, members of the parents' bridge club visited at three- to four-day intervals after the first few days; the parents recalled the visits as helpful. It was universally agreed that staying busy was very important. Two families had moved from houses that they found unbearwithout their deceased children. Another family took a two-weeks' trip after the death occurred.

At the time of the interview all parents were outwardly functioning satisfactorily. There had been no divorces or separations. Two mothers had required hospitalization because of "nerves." One family was so disturbed by the interview that it had to be ended prematurely. Their son had had lymphosarcoma and had been acutely ill during the four months that he lived after the diagnosis. Although it was not uncommon for mothers to weep, none of the other interviews had to be stopped before completion.

Unhealthy psychological situations were found to involve siblings of the deceased children. Two children had nightmares and difficulties with school work. One child kept all her older sister's old toys aligned in a certain order and became furious when neighborhood children disturbed them. Because of the mother's fear of losing a sec-

ond child from leukemia, she had monthly blood counts made on this little girl.

More than half the families had pictures of the child in view and stated that they were able to talk about the child with friends. In other homes no pictures were seen. Many parents admitted that they rarely discussed their child with others. They had difficulty in talking during the interview.

Family additions

Among the 15 families, two mothers were pregnant at the time of diagnosis. One was delivered three weeks before the death of the leukemic child, and the other eight months before death occurred. The parents whose two children were adopted, adopted another child two years after the death. Two other families had babies from 18 to 20 months after the death of their sick child.

A mother who had one child living stated that she knew she should have another, but her first pregnancies had been difficult. Her history included one spontaneous abortion. She also feared that another child would be abnormal. In another family in which there were no living siblings, the mother wanted other children but the father did not. There had been an earlier spontaneous abortion in this family, too. This father had remained with the child in the hospital a major part of the time—a role the mother usually played. Another mother stated that she had stood all the pain she could and did not want to chance being hurt again. Still another said that her deceased daughter had been "everything I could want in a girl." No other children could take her place.

Miscellaneous

All but one of the families stated that they had tried to learn everything they could about the disease, consulting medical texts, home medical books, and newspaper and magazine articles. When shown a recent pamphlet on the subject, they thought it would have been useful.

Eleven families wanted to return to the

medical center to see their child's physician. Four actually did return. The mother whose husband had committed suicide thought that a return visit would not have been worth while. No answer to this question was recorded in two cases. Other parents did not return because they thought the doctor would be too busy to see them.

Many parents asked about new developments in the understanding and treatment of leukemia. Others wanted to know about the risks their other children faced.

Many families who became acquainted while their children were ill kept in touch after they died.

Although not queried specifically, none of the families regretted that their child had received chemotherapy. One grandmother had advised against any therapy, but the parents were glad they had not followed her advice. The parents wanted everything possible in the way of therapy—in one case, to the extent of making a trip to Florida to see a faith healer.

As indicated before, all the children in this study died from a disease their physician could not cure. Nevertheless, there was not one indication at any interview of hostility toward the physician. In fact, there seemed to be a feeling of appreciation for what he had done.

Discussion

The information gleaned from this study will now be integrated with the findings of others into suggestions for the psychologic care of a child with leukemia and his family.

An accurate diagnosis is the foremost factor in dealing with the family. When the clinical picture and laboratory data suggest leukemia, it is necessary to make the definitive diagnosis by bone-marrow examination as soon as possible. This may mean immediate referral to a medical center, or the attending physician may do the study himself. The urgency of a diagnosis in either case is important for two reasons: (1) the family will probably suspect the diagnosis and feel great anxiety, and (2) an early diagnosis and immediate institution of ther-

apy will enable the family to feel later that "everything was done soon enough." Green and Solnit¹¹ have recently discussed some of the consequences of a mistaken diagnosis.

With the diagnosis in hand, the physician must inform the family. As Farber¹² states, "The truth should be told . . . kindly, and preferably in a room removed from the hurly-burly of the clinic." He continues that the term "acute leukemia" should not be used until "a relationship based on confidence in the physician has been established."

Orbach and others² emphasize that the parents have a "deep need to preserve some hope in the child's eventual recovery." They believe that parents want to keep their children alive as long as possible. That no cure is presently known must be made clear; however, these authors believe that research or experimental therapy should be offered to preserve some hope and let the parents feel that they have done everything possible.

Time should be available to reply to however many questions the parents may ask. Farber¹² says it so well: "Parents must be prepared for the eventual loss of the child —or even the termination of the illness in a very short while—without depriving them of the hope that prolongation of life may in itself preserve the child for benefits of research yet to come."

Orbach and others² state that the "period immediately following the diagnosis is a time of intense parental anxiety manifested by hostility toward doctors, failure to comprehend the information given, acute feeling of personal responsibility for the illness, disruption of functioning, or separation fears." One can understand why Davis¹³ says these people need "mothering."

The physician must expect hostile attitudes in parents as a normal reaction. He should not become angry. When consultations are requested, he should get them. It is his responsibility to assure the parents that they could not have prevented the illness nor its outcome. His responsibility extends to seeing that the family obtains food,

lodging, and sedation if necessary. One mother in this study remembered being lost and lonely after her arrival at the medical center. She was not "mothered" enough. A social service worker is invaluable in such cases. A social worker may also help the mother organize the household chores that need to be done in her absence. Suggestions as to what to tell neighbors, family, and siblings are useful.

After the initial period of protest, most parents accept the diagnosis. It is now that they are eager for information about the disease. The pamphlet prepared by the National Cancer Institute¹⁰ can be of help. As the parents remember little of what has been told them at the time of diagnosis, the physician must be prepared to answer any questions that the parents have, even though they have been answered before.

The importance of parents' being able to identify a single doctor as their child's physician is emphasized in two reports. 9,2 He should be the one on whom they can rely both during hospitalization and during stays at home. Many treatment centers have residency programs with a relatively high turnover. Here parents receive less than the best psychologic support in that there is no single physician whom they can identify as their child's.

While there are no easy solutions to the psychological problems attending leukemia, Williams¹⁴ offers some suggestions:

Desirable plans for medical service at the university hospital include the following: physical segregation of the majority of patients according to the main type of disability, but a pooling of others in general medical units; uniformly excellent care for all patients, with no segregation according to financial status; and major responsibility for the activities of these units under the respective specialty chiefs and general internist."

The emotional need of the hospitalized child has recently been reviewed by Mason. ¹⁵ He and Richman and Waisman³ imply that the liberalization of visiting hours has a positive effect on both child and family. The families in this study were universally appreciative of extended visiting privileges and were extremely bitter when, owing to a

misunderstanding, they were asked to leave the child's room. Richman and Waisman suggest, and Hamovitch²⁰ shows, that the parental participation in the routine care of their children can be helpful to both parent and child. A necessary corollary is an understanding, mature nursing staff who give verbal and silent approval of the parent's help and can assume full care when this best meets the needs of the family. To expect such maturity from all nurses working on a general pediatric ward is no small order.

Another liability of liberalized visiting hours and parental participation in the care of their children is that the other members of the family will be completely neglected. It is also necessary that the mother get adequate rest and nutrition. Parental participation in the care of their children is nevertheless a worthy goal.

Many children experience a remission and subsequent relapse requiring hospitalization. On readmission the fears of separation are revived.² Several mothers in the present study were distressed by having to repeat the complete history of the case to a stranger, usually a medical student, and again when the house officer and medical student performed separate examinations on these acutely ill patients. Such evidence causes us both to agree and disagree with Feinstein.16 Because the history and physical examination of these patients require the fullest employment of both the art and the science of medicine, one examination would seem to serve the best interests of patient, parents, and student, the latter observing while the physician makes the examination, as suggested by Feinstein. That the history must be repeated in its entirety to the admitting house officer on each readmission, is, however, in our opinion, unnecessary and perhaps unwise.

As death approaches, the family needs the physician. Friedman and others⁶ remind us that even though the physician feels that he can be of no more help to his patient, his mere presence in the room every day comforts the family.

Following the advice of Solnit and Green,9

the physician should be sure that the parents are aware of an imminent fatal event. Should they be out of the hospital, he should telephone them to come, having prepared them in advance for such a message. When the parents are in the hospital they will undoubtedly know of the death as soon as, if not before, the physician does. He should come to discuss the circumstances with the family as soon as possible. Solnit and Green advise the physician to be prepared to answer questions and, more important, to listen as the parents initiate their immediate grief reactions. Although these authors recommend that the physician offer to see the parents later, the American literature dealing with the psychologic care of leukemic families has not, in our opinion, given a return visit the emphasis it deserves.

In the present series 11 parents stated that they would have liked to return to talk with their child's physician, and 4 actually did. Other studies^{6,7} report favorable impressions of the follow-up interviews, but fail to include the recommendation that it be a necessary part of the care of these families.

Williams, an Australian pediatrician from the Royal Children's Hospital of Melbourne, appreciates the importance of a follow-up' interview. He says:

I have found that a single interview at the time of death has been incomplete and unsatisfactory from several points of view. There are often a number of questions that can be discussed only at a time when parents have had the opportunity to adjust to the loss of their child, and when the results of the postmortem examination are known. After an initial interview at the time of death, parents have been given the opportunity to talk with me one to three months after the child's death. The majority of them have welcomed such an opportunity, and considerable experience leaves me in no doubt of the value and importance of this second interview.

The interviews reported here were characterized by the parents' having unanswered questions. There were unhealthy attitudes and perhaps pathologic grief reactions among these families.

Robbins¹⁸ says:

We can no longer divide life into segments

such as fetal, neonatal, childhood, adolescence, adulthood, and senescence. Rather, it is a dynamic continuum with the status at any one point in time being influenced by all that went before and in turn, having an effect upon all that follows.

If he speaks the truth, then the follow-up interview would certainly be of value from the standpoint of helping families with psychologic problems needing therapy. Just as important is the role that these interviews can play in preventing unnecessary psychologic trauma to the parents and the siblings of the dead child. The follow-up interview should not be underestimated, and should become a part of the care of these families.

It is well to recall that all patients and their families must be treated individually. One must be able to recognize the exceptions to the rule.

Summary

A series of 15 interviews was conducted with parents of children who died from leukemia 11 months or longer prior to the interview. The purpose was to evaluate the psychologic care given these patients and to look for regional pecularities.

Mistakes had been made in the care of these patients and especially of their parents. No outstanding regional peculiarities were noted.

Several suggestions for improving the care of these people are made. The importance of an interview with the parents some months after the death of the child is stressed.

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All strong liquors are hurtful to children. Some parents teach their children to guzzle ale, and other fermented liquors at every meal. Such a practice cannot fail to do mischief. These children seldom escape the violence of the small-pox, measles, hooping-cough or some inflamatory disorder. William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 35.

Open Heart Surgery for Multiple Valve Disease

FRANCIS ROBICSEK, M.D., PAUL W. SANGER, M.D., HARRY K. DAUGHERTY, M.D. and ALI KARBASIAN, M.D. with the technical assistance of EMANUEL BAGBY CHARLOTTE

A few years ago advanced lesions of more than one heart valve constituted a contraindication for cardiac surgery. Contraindications of yesterday, as often happens, have become operative indications of today. A handful of cases involving successful surgical attacks on two or more heart valves have been described. 1,2,3,8,9 It is likely now that such operations will rapidly increase.

The decision to operate on a severely ill patient with malfunctioning heart valves is certainly not an easy one. Not only is the concept of multivalvular surgery of interest to the surgeon but to every physician who treats acquired heart disease. Because of the limited experience in this field, we thought it timely to present the brief clinical case summaries of eight patients with bi- and tri-valvular operations, the technique employed, and the results obtained therewith.

Selection of Patients

We recommend surgery for multiple valvu'ar disease under the following circumstances:

- 1. Patients under the age of 60 who cannot be gainfully employed because of cardiac incapacity.
 - 2. Progressive heart enlargement.
- 3. Repeated episodes of congestive heart failure.
- 4. Poor response to conservative medical therapy
 - 5. History of embolization.

During the past four years we have operated on 102 patients with acquired heart disease, using the "open" technique with cardiopulmonary bypass. The first "multivavular" operation was done in early 1961.

Since then 8 additional patients (8.72%) have undergone valvuloplasty or replacement of two or three heart valves.

Patients were selected mainly on the basis of the clinical symptoms and physical findings. All eight patients had had rheumatic heart disease for more than ten years. Six out of eight had had multiple episodes of congestive heart failure. When hospitalized, seven were classified as group IV (according to the New York Heart Association Classification), and two as group III. No patient was denied multiple valvular surgery on the basis of the severity of the cardiac disability.

Three-plane roentgenography, cardiac fluoroscopy, 12-lead electrocardiography, and in most cases, left and right heart catheterization were essential parts of the preoperative studies. The patients spent an average of eight days in the hospital preoperatively undergoing intensive medical treatment.

Technical Considerations

Details of valvuloplasty or prosthetic replacement⁹ will not be discussed in length. Attention is given only to special problems particular to multiple-valve operations.

All patients were operated on through a mid-line sternum-splitting incision. The approach does not give an easy access to the mitral valve as does the left-sided thoracotomy recommended by Cartwright: however, it provides excellent exposure to control the entire heart, and makes access to the tricuspid valve possible.

All these operations were done under conditions of normothermia, high-flow total-body perfusion, elective cardiac arrest, and topical cardiac hypothermia. The heart was cooled by bathing and irrigating its interior with normal saline-sluch and ice-cold saline solution. With the use of normothermic total-body perfusion no time was lost in

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Fig. 1. Direct vision valvuloplasty in cardiopulmonary bypass and topical cardiac hypothermia: (A) tricuspid, (B) mitral.

cooling and warming the patient, the incidence of metabolic disturbances was considerably less, and the recovery was much smoother than in our previous cases in which "deep" or "moderate" hypothermia was used. Abandoning coronary perfusion and using topical hypothermia instead, we gained further time and were able to work on an empty, quiet heart free of "coronary return" blood. Consequently hemolysis and hematuria were rarely seen. This practice is contrary to that of most surgeons, who stress the importance of continuous coronary perfusion. In our experience⁷ the heart protected by hypothermia tolerates anoxia extremely well for periods of 60 to 80 minutes, and fairly well up to two hours. When both the mitral and aortic valves were replaced, 25-minute coronary perfusion was allowed between the two phases of the procedure.

Special care was taken to prevent overdistension of the heart during perfusion

and to forestall air embolization. For this purpose the cold arrest of the heart, crossclamping of the ascending aorta, and opening of the left atrium were carried out in rapid sequence. To complete the operation on the mitral valve, a catheter was inserted through the mitral orifice into the left ventricle, brought out through the atriotomy incision, and connected to gravity drainage. Before releasing the clamp of the aorta, all the air was meticulously expelled from the left side of the heart through a large-bore needle inserted into the aortic root as recommended by Effler.7 The left ventricular drainage catheter was withdrawn into the left atrium only after the heart resumed a forceful beat.

Case Reports

Mitral and aortic disease

Case 1: Our first patient, a 26-year-old housewife, was known to have had rheumatic heart disease since the age of 7. She had had repeated episodes of heart failure and had been on a regimen

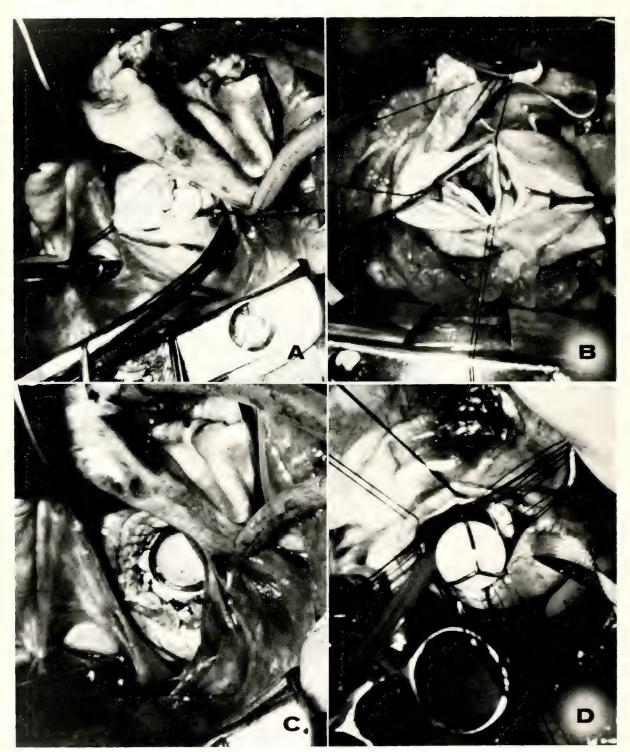


Fig. 2 (Case 1). Simultaneous replacement of the mitral and aortic valves with Starr-Edwards ball-valve prosthesis; the exposed, grossly incompetent mitral (A) and aortic (B) valves. In views C and D the respective valves have been replaced by ball-valve prosthesis.

of diuretics and digitalis for the past 15 years. Her symptoms progressed to such an extent that she

had been bedridden and unable to take care of herself for the past four months.

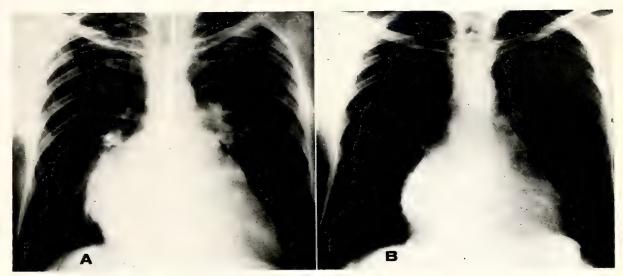


Fig. 3 (Case 2). Posteroanterior roentgenogram of the chest taken before (A) and six months after (B) simultaneous replacement of the mitral and aortic valves.

Physical examination revealed a young woman, slightly cyanotic and dyspneic at rest. The liver felt enlarged and there was pitting edema of the ankles and sacral area. The pulse was irregular and unequal—110/minute. Blood pressure was 110/35 mm. Hg. There was an apical systolic thrill and a grade IV apical systolic murmur. A systolic murmur was also noted over the upper part of the sternum, right second interspace parasternally, and suprasternal notch. A diastolic murmur was heard in the left third and fourth interspace parasternally.

X-ray examination of the chest showed pulmonary vascular engorgement, marked dilation of the left atrium, and enlargement of both ventricles. Electrocardiography revealed atrial fibrillation and was suggestive of biventricular hypertrophy.

After ten days of intensive medical treatment the patient was operated upon. Both mitral and aortic valves were explored in cardiopulmonary bypass and found to be severely regurgitant and moderately stenotic due to scarring and calcification. The valves were excised and replaced by a Starr-Edwards ball-valve prosthesis.

The patient went through the operation well. The postoperative course was complicated by moderate speech difficulty and a mild psychotic reaction. During her hospitalization this cleared completely. On the twentieth postoperative day she was discharged and has been followed up closely since then. She is now free of clinical symptoms and has no difficulty in taking care of herself and her family.

Case 2: This patient was a 38-year-old salesman who had had several episodes of rheumatic fever and had been treated for valvular heart disease for the past 14 years. He had severe dyspnea on exer-

tion and also some breathing difficulties at rest.

Physical examination revealed an undernourished man with cyanosis of the lips and fingernails and distended neck veins. The pulse was irregular and unequal—99/minute. The blood pressure was 120/60. The apical impulse was felt in the left anterior axillary line. There was a grade IV holosystolic murmur audible over the entire precordium (maximum point of auscultation at the apex), but it was also well transmitted toward the aorta. There was an apical presystolic rumble and a separate holodiastolic murmur in the left 3-4-5 interspace parasternally.

X-ray examination revealed aneurysmatic dilation of the left auricle, a high degree of enlargement of both ventricles, and dilation of the right atrium. Electrocardiogram showed atrial fibrillation suggestive of myocardial ischemia.

Using total body perfusion, the mitral valve was explored and found to be calcified and grossly regurgitant. The aortic valve did not contain calcium, but two of the cusps were herniated into the left ventricle giving rise to severe cardiac insufficiency. Both valves were excised and replaced by Starr-Edwards prosthesis.

The patient's breathing was assisted by a respirator during the next three days. He was taken off the respirator gradually, became ambulatory on the sixth postoperative day, and was discharged from the hospital 18 days after operation. He is now working full time as an office manager.

Case 3: The third patient was a 34-year-old housewife completely incapacitated by rheumatic heart disease. She had experienced heart failure several times and had been in and out of different hospitals during the past six months.

Physical examination showed a thin young wom-

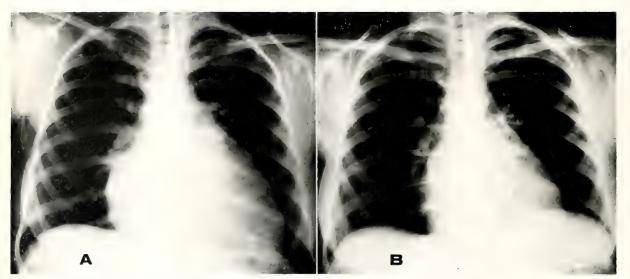


Fig. 4 (Case 3). Posteroanterior roentgenogram of the chest taken before (A) and eight months after (B) simultaneous replacement of the mitral and aortic valves.

an who appeared to be chronically ill. The blood pressure was 130/40. There was an apical systolic thrill and an apical grade IV systolic murmur. A blowing diastolic murmur was heard in the left 2, 3, 4 interspace parasternally.

On x-ray examination the heart was found to be enlarged—primarily the left atrium and left ventricle. The electrocardiogram revealed left ventriculary extrapolary.

At the time of surgery both the aortic and mitral valves were found to be fibrotic and partially calcified, moderately stenosed, and grossly incompetent. They were resected and replaced by Starr-Edwards ball-valve prosthesis.

The patient's postoperative course was uneventful and she was discharged on the seventeenth postoperative day. She continued to do well and is now free of cardiac symptoms.

Case 4: This patient, a 47-year-old housewife, had a history of rheumatic heart disease for the past eleven years. Probably as the result of a cerebral embolus her left side became completely paralyzed. This paralysis, however, cleared completely. Eight years previously she had undergone a "closed" mitral commissurotomy. During the next six years she did fairly well. In the last two years, however, her previous symptoms—that is, fatigue, difficult breathing and palpitation—recurred and she was treated repeatedly for congestive heart failure.

At the time of her admission to the hospital she had atrial flutter which responded well to quinidine therapy. The liver exceeded the costal margin by two fingerbreadths, and there was pitting ankle edema. The pulse rate was 100/minute and the blood pressure 130/65 mm. Hg. A grade IV systolic

murmur and also a short presystolic rumbling murmur were heard at the apex. A separate, holodiastolic murmur was audible in the left third interspace parasternally.

X-ray studies of the chest showed heart enlargement of medium degree, prominent pulmonary conus, and dilatation of the left atrium and the left ventricle. Electrocardiogram revealed left ventricular hypertrophy. Retrograde catheter aortography confirmed the presence of incompetence of the aortic valve clinically suspected.

Following intensive medical therapy, the patient underwent surgery. The mitral valve was extensively calcified, severely stenosed, and grossly incompetent. The aortic valve also contained some calcium and was regurgitant. Both valves were excised and replaced by a Starr-Edwards prosthesis.

The postoperative course was complicated by several episodes of rapid atrial fibrillation and tachycardia. This was treated by direct current countershocks. Her recovery was somewhat slow but complete. She was discharged on the twenty-fourth postoperative day and has now resumed normal physical activities.

Case 5: Our fifth patient was a 48-year-old man who had a 17-year history of rheumatic heart disease. He was hospitalized seven times for congestive heart failure and once because of myocardial infarction.

At the time of admission he had cyanosis of his cheeks, lips and fingernails. He could walk to the bathroom only with help and was severely orthopneic. The pulse rate was 110/minute, blood pressure 130/60. There was a harsh apical systolic murmur and also a blowing diastolic murmur in the

left third and fourth interspace parasternally.

Chest roentgenograms showed significant dilatation of the left atrium and enlargement of the left ventricle. An electrocardiogram revealed left ventricular hypertrophy and was suggestive of an old posterolateral infarction. Left heart catheterization confirmed the diagnosis of advanced mitral and aortic regurgitation.

Following two weeks of intensive medical treatment the patient was operated upon. The mitral valve was calcified, stenosed, and regurgitant. The aortic valve appeared to be thickened and grossly regurgitant. Both valves were excised and replaced by ball-valve prosthesis.

During the first two postoperative days the patient's condition was extremely poor. He had to be ventilated artificially and blood pressure had to be supported by vasopressors. After this period he showed considerable improvement until the fourth day after surgery, when he suddenly became cyanotic, complained of severe air hunger, and expired in spite of all resuscitative measures. An autopsy showed the valvular prosthesis to be in a satisfactory position and the left main bronchus blocked by a large mucus plug.

Mitral and tricuspid disease

Case 6. Our sixth patient was a 41-year-old housewife who had rheumatic fever at age 11. Sho was known to have had a heart murmur for the past ten years, but was symptomless until the past



Fig. 5 (Case 4). Lateral roentgenogram of the chest following bivalvular replacement.

three. Since then she had developed orthopnea and paroxysmal nocturnal dyspnea of increasing severity.

The neck veins appeared quite distended on physical examination. The pulmonary second sound was accentuated and there was an apical

Table 1 Analysis of Cases

No.	Diagnosis	Age	Group*	Procedure	Perfusion Time (Min.)	Results
1. A	Aortic and mitral regurgitation	26	IV	Aortic and mitral valve replacement	130	Excellent
	Aortic stenosis, mitral stenosis and regurgitation	38	IV	Aortic and mitral valve replacement	128	Excellent
3. A	Aortic and mitral regurgitation	34	IV	Aortic and mitral valve replacement	110	Excellent
	Aortic regurgitation, mitral tenosis	47	IV	Aortic and mitral valve replacement	108	Excellent
5. A	Aortic and mitral regurgitation	48	IV	Aortic and mitral valve replacement	120	Expired
	Mitral stenosis and tricuspid egurgitation	41	III	Mitral replacement, tricuspid venoplasty	24	Excellent
	Mitral stenosis and tricuspid regurgitation	38	IV	Mitral replacement, tricuspid venoplasty	110	Excellent
	Aortic, mitral and tricuspid stenosis	33	III	Aortic, mitral, tricuspid venoplasty	45	Excellent
	Aortic, mitral and tricuspid tenosis	33	IV	Aortic, mitral, tricuspid venoplasty	75	Excellent

^{*}New York Heart Association classification.

systolic presystolic murmur, rumbling. A diastolic murmur was also heard over the lower part of the sternum, right and left fourth interspace parasternally.

Chest roentgenograms revealed prominent pulmonary conus and hypertrophied right ventricle. An electrocardiogram showed right ventricular preponderance. Right heart catheterization gave evidence of pulmonary hypertension (62/36 mm Hg) and also showed a pressure gradient of 9 mm Hg across the tricuspid valve.

In cardiopulmonary bypass the tricuspid valve was exposed through a right artiotomy incision. The area of the tricuspid orifice measured less than 1 square centimeter. Using the Gerbode dilator, the fused commissures were fractured and the orifice enlarged to approximately 3 square centimeters. By incising the interatrial septum, the mitral valve was then exposed. Both commissures were fused, but the leaflets remained pliable. Using again the Gerbode dilator, a commissurotomy was done under direct vision and a normal size mitral orifice was restored.

The patient had an undisturbed recovery and was discharged on the thirteenth postoperative day. She is now able to perform normal household activities without difficulty.

Case 7. This patient, a 38-year-old postal clerk, had had a heart murmur since 14 years of age. He had been on a regimen of digitalis and diuretics for several years and had been hospitalized twice for congestive heart failure. He was hardly able to walk a block without stopping several times. Because of severe exertional dyspnea he had limited his physical activity to the minimum.

On physical examination the patient appeared chronically ill, with distended, pulsating neck veins and an enlarged, pulsating liver. Lips and nails were cyanotic. There was a harsh, musical systolic murmur over the entire precordium and a diastolic-presystolic murmur at the apex. The pulmonary second sound was stringly accentuated.

On x-ray films the heart appeared enlarged, the pulmonary conus prominent, and the vascular markings heavy. Both atria were dilated and the right ventricle was hypertrophic. The left ventricle appeared normal in size. Electrocardiogram showed right ventricular hypertrophy and was suggestive of myocardial ischemia. Catheterization of the right and left sides of the heart and angiocardiography revealed large, "regurgitant" C-waves, synchronous with ventricular systole, in the right atrium. There was no pressure gradient across the aortic valve. The pulmonary artery pressure measured 58/40; "wedge" pressure 26/22 mm. Hg. Dye injected into the left ventricle did not regurgitate into the left atrium.

Under direct vision and total body perfusion, the tricuspid valve was approached at first. The annulus was tremendously dilated, but the valve

leaflets appeared to be intact. Using Mercilene 00 mattress sutures, a tricuspid annuloplasty was performed. After testing the competence of the tricuspid valve, the severely stenotic and heavily calcified mitral valve was excised through the trans-septal approach and replaced by a Starr-Edwards prosthesis. The total perfusion time was one hour and 48 minutes.

The patient had a "stormy" postoperative course, and his respiration had to be assisted by a March respirator for five days. After this period, however, he made a remarkable recovery. He was discharged fourteen days postoperatively and is now back in full-time work. Except for monthly injections of Bicillin and maintenance doses of anticoagulants, he receives no other medication.

Mitral, aortic, and tricuspid disease

Case 8: This patient was a 33-year-old nurse who was seeking medical advice because of exertional and paroxysmal dyspnea, fatigue, and ankle edema. She did not have a history of rheumatic fever, but was known to have had a heart murmur since childhood.

On physical examination the neck veins appeared distended. There was a systolic thrill and a Grade III systolic murmur over the entire precordium, with a maximum point of intensity in the left third interspace parasternally. The murmur was well transmitted toward the aortic arch and carotid arteries. A diastolic murmur with a presystolic accentuation was heard at the apex.

Chest x-ray films showed diffuse cardiac enlargement involving all the four chambers and prominence of the pulmonary conus. Electrocardiography showed "mitral" P-waves, bi-ventricular hypertrophy, and strain. Right heart catheterization revealed pulmonary hypertension, elevated "wedge" pressure and a 12 mm Hg pressure gradient at the tricuspid orifice.

A diagnosis of combined mitral, aortic, and tricuspid stenosis was made, and the patient was prepared for surgery. First the right atrium was opened, and by incising two of the three tricuspid commissures, an orifice of nearly normal size was reconstructed. Through the interatrial septum the mitral valve was then approached. Similarly to the tricuspid, it was found to be severely stenosed but free of calcification. A commissurotomy was done without difficulty. After the closure of the interatrial septum and the suture of the atrial wall, the aortic valve was exposed through the aortotomy incision. It was bicuspid with both commissures fused, narrowing the effective orifice to approximately 1 square cm. The valve itself was only moderately scarred and pliable. The fused commissures were separated by sharp dissection.

The patient was discharged on the fourteenth postoperative day and is now back in full-time nursing.

Case 9: This 33-year-old housewife, mother of three, had rheumatic fever at the age of 8. Her physical activities had been limited since then. Five years previously she had undergone a "closed" mitral commissurotomy. Her condition improved temporarily, but she had had a relapse during the last year. Hemoptysis and ankle edema developed, and she had several "blackout spells" during which she was unconscious for several minutes, but there was no residual cerebral damage.

Physical examination revealed an undernourished woman with distended neck veins, ankle edema, and cyanosis of the lips and nails. There was an apical harsh systolic murmur and also an apical diastolic-presystolic murmur. The pulmonary second sound was accentuated. A systolic murmur was also heard in the right second interspace, with transmission toward the aortic arch and carotid arteries.

X-ray examination of the chest showed the heart to be enlarged. Both left and right atria were dilated and the ventricles appeared to be hypertrophied. "Mitral" P-waves and signs of bi-ventricular hypertrophy were seen on the electrocardiogram.

After being treated with bed-rest, digitalis, and diuretics, the patient underwent open heart surgery. The right atrium was entered at first and a tight tricuspid stenosis was corrected by incising two commissures. The mitral valve was explored through the atrial septum. It was severely stenotic—the leaflets thickened but not calcified. By incising both commissures, a normal size orifice was easily restored. The aortic valve was exposed through an aortotomy. The commissures were fused and there was a moderate amount of calcium deposited on the leaflets. The commissures were incised and the deposits were removed by sharp dissection.

The patient had no difficulties going through surgery nor in the postoperative period. She was discharged on the sixteenth postoperative day and is now working as a sales clerk in a department store.

Comments

The concept of multivalvular surgery is not new, but the technical developments have been slow. Multiple valvuloplasties were carried out sporadically as far back as the late 1950s but even in the hands of the most experienced surgeons, the mortality remained forbiddingly high. The first trials of bivalvular replacements were carried out by Cartwright, in 1961 and Starr, in 1962. Unfortunately, both patients died because of late complications. Results like these may have been why Effler, two years ago, recommended that

double replacements with the Starr-Edwards prosthesis should be accomplished as a two-stage rather than a one-stage procedure.

Recent results showed a dramatic improvement. Starr¹⁴ reported 27 patients operated upon with multiple valve disease, 20 alive and in good condition-total mortality of 26 per cent. Nelson and Cooley8 replaced the aortic and mitral valves simultaneously in two instances. Both patients went through surgery without difficulty. Schimert and associates¹³ gave a thorough clinical and physiologic report of 18 patients having multiple valve replacement with an overall mortality rate of 16 per cent. Discussing Shimert's paper, Herr⁶ described his experiences gained in 45 single stage, multiple replacements with an overall mortality rate of 16 per cent.

In our experience, the two most important factors in decreasing operative mortality are the length of the cardio-pulmonary bypass and the completeness of the valvular repair.

A significant effort should be made to limit the time of the perfusion. This can be accomplished by the simplification of the technique and effective operative teamwork. Using a simplified technique of perfusion and topical cardiac hypothermia, we were able to reduce our average perfusion time to 45 minutes for multiple valvuloplasty and to two hours for bivalvular replacement. This compares favorably with the data published by others, whose perfusion time ranged from three to five hours¹³ or an average of 3 hours and 17 minutes.¹⁴

The sine qua non of a complete functional repair is that the surgeon should have an adequate knowledge of the existing pathologic condition. In some cases the need for exposure of two or three valves is obvious. The dominant lesion may mask others, that are less obvious. Preoperative hemodynamic studies—right and left heart catheterization, left ventricular cardiography, and supravalvular aortography—could not be emphasized sufficiently.

A difficult problem in surgical judgment is posed when there is advanced disease of

one valve and mild stenosis or regurgitation of the other. One might be tempted to ignore the other, hoping that good results might be obtained by operating only on the more involved valve.

While occasionally successful, this limited approach to multivalvular disease may be dangerous.8 It is well to remember when using the "closed" mitral commissurotomy technique that a "mild" aortic condition sometimes suddenly gave rise to serious symptoms after opening up the mitral valve. Similarly poor functional results --- even death-may occur after "successful" surgery on the aortic valve because mitral pathology was overlooked or not fully appreciated. Therefore, it is mandatory that a surgeon should not only gather all the diagnostic data before surgery, but also keep an open mind after the exposure of the heart, confirm the preoperative diagnostic findings, and continue to search for missed clues. Even if the procedure is planned as a one-valve operation, the aorta, pulmonary veins, and the exterior of the individual chambers should be palpated for thrills. The tricuspid valve should be routinely explored by finger at the time of cannulation. Similarly, the aortic valve should be palpated through the mitral orifice if surgery is performed on the bicuspid valve. If doubt exists, the valve in question should be exposed and inspected.

We had an overall mortality of 10.4% out of the last 67 consecutive patients on whom we operated in cardiopulmonary bypass because of acquired heart disease. Interestingly enough, only one out of nine (8.72%) patients undergoing multivalvular surgery was lost during the same period. This certainly is encouraging to extend the operative indication on multivalvular disease.

Due to increasing experience and the development of better prosthesis, heart surgery has reached a stage predicted by Starr¹⁴ and "... the risk of surgery in multiple valve disease has approached that of surgery for isolated valve disease and patients are selected for surgery on the same basis."

Summary

The case histories of nine patients with advanced acquired heart disease involving two or three heart valves are presented. They underwent single-stage repair of all diseased valves, eight of them with satisfactory results. One patient was lost on the fourth postoperative day. The concept of multivalvular surgery, including selection of the patients, pre- and intra-operative evaluation, and some technical aspects are briefly discussed.

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Islamic-Persian Medical Education

A Survey from Jundi-Shapur to Cairo

GEORGE PODGORNY, M.D. WINSTON-SALEM

Conclusion

Teaching Centers of Islam's Golden Age Baghdad

We have already mentioned a few hospitals that were built in Baghdad. Abernethy has said: "The hospital is the only proper college in which to rear a true disciple of Aesculapius." During the golden age of Islam this was exactly the case. Almost every hospital—and there was one or more in every large city—was a teaching hospital. Of course not every hospital was associated with a medical school, but the majority conducted a certain amount of training.

The last hospital to be built by a teacher from Jundi-Shapur, as said previously, was the Bimaristan-al-Rashid in Baghdad (786). Almost a hundred years passed before another major hospital was built, this one by Ahmad-ibn-Tulun in Cairo in 872. In this hospital mostly surgeons, both civilian and military, were taught and trained.

Next in chronological order of teaching hospitals was Bimaristan al-Muqtadiri, built in 918 by Caliph Al-Muqtadir. Many famous physicians practiced and taught in this hospital.¹⁵ It is likely that Rhazi was on its staff.

Adud-al-Dowla Deylami, Persian king and caliph's vassal, rebelled in 969 (975, ac-

For editorial comment see page 212

cording to Sarton) and entered Baghdad as conqueror. He left Caliph Ta'is unharmed and administered his empire from Baghdad. Adud-al-Dowla's hospital in Shiraz is famous and will be mentioned later; however, it was overshadowed by the Bimaristan Adodi, which he founded in Baghdad in 979. It later became known as the New Hospital to distinguish it from the Old Hospital of Al Mansur's time.

From the Department of Surgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem.

This hospital had a well equipped medical school which was divided into departments and sections, and famous physicians had double appointments as chiefs of services in the hospital and departmental directors. Among them were such notables as Abu-ul-Salt, the orthopedist, Abu'al-Khayr, the surgeon, and Abul Harryn "Ali-ibn Kashkaraya, the famous Persian master of Enemata." ¹⁵

There was reason for the best physicians of those days to come to this hospital. The prestige of holding a teaching appointment as well as the monthly stipend of 300 dirhams (about \$1200) awaited them on establishment of the hospital, and the school opened with an endowment of \$250,000 and a full-time teaching staff of 21 physicians, later increased to 80.19

According to Ibn Abi Usaybia, this school had an anatomy theater where apes and monkeys were dissected, and the buildings boasted running water brought from the Tigris.¹⁸ As late as 1184, the hospital flourished and its teaching was highly regarded, according to Ibn Jabir.

Shiraz

Adud-el-Dowla also built a great hospital in Shiraz at the end of the tenth century. This formed a part of a large university, with schools of philosophy, astronomy, alchemy, mathematics, and medicine. The medical school followed exactly the lines of the school of Jundi-Shapur. A basic science course was taught in the university school where students were encouraged or required to attend courses in the field of philosopy or mathematics.

Damascus

Turning to Syria and a later period, we are impressed by the work of one man in building two of the finest teaching centers of Islam.

Nur-al-Din Zangi "Atabek" of Aleppo (of Crusades fame), ascended the Egypto-Syrian throne in 1146. Shortly thereafter a Frankish king was captured during the Second Crusade. Upon receiving a large ransom for his release, Nur-al-Din decided to use it for a badly needed hospital, and so the Bimaristan Nuri of Damascus was built in 1154. A generous endowment was set up for the hospital, and leading physicians were called to its service.

The teaching and practice of therapeutics were outstanding at this center. Ibn Abi Usaybia, who is often quoted and referred to, studied and practiced there. A beautiful and elegant room was reserved for the examination of dignitaries. Regular ward rounds were conducted daily for the students. All sources indicate that no basic science school existed at the Nuri hospital. Usaybia wrote:

Abu-al-Majd-ibn-abi-al Hakam, the chief of medicine, made rounds at the Nuri hospital in Damascus every morning accompanied by physicians and students; then they used to come to him and sit at his feet. He taught the students and discussed medical topics and difficult cases. After three hours of lectures, discussions, and book reviews he rode to his house. 15

According to Ibn Jabir, a great traveler, in 1184 there was a large medical school and hospital at Harran near the Tigris (in the region of the present-day city of Mosul in Iraq). However, no details of this institution were given.¹⁸

The last hospital of importance to be built in Baghdad was the college hospital of Al-Mustansiriyya. The Abbasid caliphate was coming to its end, Ghengis Khan was literally chewing up the Moslem Empire, and Baghdad was enjoying its last decades of freedom. Al Mustansir's (next to the last Abbasid caliph) only claim to distinction was the founding of the famous Mustansiriyya College. In magnificence, in external appearance, in ornamentation and luxurious furnishings, it is said to have surpassed anything that Baghdad had ever seen before. The Caliph himself laid the foundation stone, in 1227, on the eastern bank of the Tigris.¹⁰

The college, which was completed in 1234,

comprised schools of law and medicine, the latter in conjunction with the hospital. A great kitchen provided daily food for both the hospital patients and the students. The latter were allowed to copy medical books in the library and were even supplied with pens and paper.

Tabriz

In the thirteenth century, the Iranian city of Tabriz was the site of a rather unusual medical center. Mahmud the Ilkhan began his dynasty in 1295 and established his headquarters in Tabriz. One of his courtiers happened to be a Persian physician from Hamadan, one Rashid-al-Din Fazlullah, for whom Ilkhan entertained a very high regard and soon appointed Prime Minister. The famous quarter of Rub 'al Rashidi in Tabriz is still in existence and bears its founder's name. The greatest scholars of the time were congregated there. Each branch of science had a street assigned where all the scholars of the field resided. Mualejan (the Street of Healers) still exists.20 Fifty physicians, each with ten students, lived there.21

Cairo

Finally, we should consider the great Bimaristan-al-Mansuri in Cairo. Malik-al-Mansur Seyf-al-Din qualun al-'Alfi al Salehi became King of Egypt in 1279. According to some accounts, he soon became ill with ileus and was treated at Nuri Hospital in Damascus. Upon admission he promised to build a similar institution in Cairo if he should recover—which he did.

The hospital and adjoining mosque and mausoleum were built in the northeastern part of Cairo, near the Bazaar. Included in the hospital was a large lecture hall with a seating capacity of more than two hundred. Apparently general staff meetings were known then, because the medical school of the hospital was unlikely to have that many students. A large library with librarians was provided. Hundreds of outpatients were seen in the clinics by the staff and the students. The roster of the great physicians who served on the staff of this hospital is extensive. One of them was 'Abu-al-Hassan. Ali ibn-al Nafiz served as dean of the

center. He gave the earliest clear description of the pulmonary circulation, three centuries before Servetius.²³

Character of Islamic Medical Education

There is no doubt that Islam owes much to the Persians and Greeks (through the Nestorians) in the realm of medicine. It will suffice to quote the greatest Arab historiographer, Ibn Khaldun, who in his "Prolegomena to History" states:

It should be known that as far as our historical information goes, these sciences (natural) were most extensively cultivated by the two great pre-Islamic nations, the Persians and the Greeks. According to the information we have, the sciences were greatly in demand among them because they possessed an abundant civilization and were the ruling nations. In their regions and cities the sciences flourished greatly.

Among the Persians, the intellectual and medical sciences played a large and important role.24

Thus the later Islamic medical schools followed the Jundi-Shapur pattern and preserved it while moving and developing. With minor variations the following is a general picture of medical education as carried on from Jundi-Shapur to Cairo.

Medical education was serious and systematic. Teaching was done on the basis of the apprentice system, with lectures and clinical sessions. At that time Haly's excellent piece of advice to medical students was a must, and it is as timely today as it was then.

And of those things which are incumbent on the student of this art (medicine) are that he should constantly attend the hospitals and sick houses; pay unremitting attention to the conditions and circumstances of their inmates, in company with the acute professors of medicine, and inquire frequently as to the state of the patients and symptoms apparent in them, bearing in mind what he has read about those variations, and what they indicate of good or evil.¹²

Rhazi similarly advised the medical students and told them while they were seeing a patient to bear in mind the classic symptoms of a disease as given in text books and compare the two.²²

It is often said that Islamic physicians were preoccupied with theory; nevertheless

Cumston agrees that they never lost sight of the practical side of medicine. Masters gladly passed their knowledge to students and, although attending to private practice, still gave much time to teaching in hospitals. The ablest physicians such as Rhazi, Ibn-Sina, and Avenzoar all were hospital directors and deans of medical schools at the same time. They studied patients and prepared them for student presentations. Case histories were written and registers maintained.

Preliminary training

Training in the basic sciences was variable. Only in a few institutions such as Jundi-Shapur or Baghdad were there separate schools of basic studies. Usually candidates for medical study had to receive basic preparation from private tutors, and often it was limited to reading and private lectures. In Baghdad, however, anatomy was taught by dissection of apes and skeletal studies as well as by lectures. Elsewhere, lectures and illustrations sufficed.

Alchemy was another prerequisite for admission to medical school. A number of hospitals employed an alchemist who lectured and gave demonstrations for the students. In Jundi-Shapur, apparently, there was some sort of student laboratory. The study of medicinal herbs, pharmacognosy, rounded out the basic training. As mentioned before, a number of institutions maintained herbal gardens. These were a source of drugs for the patients and a means of instruction for the students.

Upon completion of basic training in a school or in private, the aspirant was admitted as an apprentice to a hospital where, at the beginning, he was assigned in a large group to a young physician for indoctrination, preliminary lectures, and familiarization with library procedures and uses. During this preclinical period lectures were mostly on pharmacology and toxicology and the use of antidotes.

Clinical training

The next step was full clinical training. In this phase the students were assigned in small groups to famous physicians and experienced instructors, for ward rounds, dis-

cussions, lectures, and reviews. Early in this period therapeutics and pathology were covered.

Islamic physicians made a great contribution to medicine by their systematic, nosologic classification of diseases. Avicenna's *Canon* and Rhazi's *Continens* are fine examples.²⁵

As the students progressed in their studies they were introduced more and more to the subjects of diagnosis and judgment. Clinical observation and physical examination were stressed.

It is recorded of Rhazi that when he was teaching at the hospital in Rey, he seated his pupils in rows according to their grades and attainments. First he would call upon the lowest class to examine a patient, and if they failed to diagnose the ailment, he would test the next and then the next. Only after all had failed would he make the diagnosis himself.²⁶

Concerning physical examination, students were taught to examine and report six major factors: the patients' actions, excreta, the nature and location of pain, and swelling and effluvia of the body. Also noted was the color and feel of the skin—whether hot, cool, moist, dry, flabby. Whether or not he could bend his back was also considered important.²⁷

After a period of ward instructions, medical students were assigned to outpatient areas. There they examined patients and reported to instructors. Treatment was decided on and prescribed. In difficult cases, a professor was called on to see the patient and discuss the diagnosis and treatment. Patients who were sick enough were admitted as inpatients. Students were responsible for keeping case records for every patient. In a period of the students were responsible for keeping case records for every patient.

Curriculum

With regard to the clinical curriculum, institutions differed in their courses; however, the mainstay was usually *internal* medicine.

Clarity and brevity in the description of a disease and the separation of each entity were looked for. Ibn Sina particularly stressed this matter, and his concern is well exemplified in his description of meningitis, which until then had been confused with acute affections accompanied by delirium.

Acute sersam is an inflammaticn or tumo of the envelopes of the brain. The prodromata of this disease consist of headache, disturbed sleep and mental depression without cause. As soon as the process becomes localized in the meninges, the first symptoms to develop are restlessness, violent headache and pains in the neck. Occasionally there is epistaxis, and slight incontinence of urine. When the disease has fully developed, all hope of cure is vain. There is then intense fever and mental depression, and the patient remains perfectly silent and indifferent to what is said to him. Respiration is rapid and irregular; the thoracic movements are, however, ample to deep, localized or generalized convulsions occur. Sleep is disturbed and accompanied by extreme restlessness and hallucinations; the patient cries out and is unable to bear light. At the terminal phase of the disease the tongue becomes paralyzed and insensibility is general; if the patient be touched with an instrument, even with considerable pressure, he feels nothing; finally the limbs become cold and the patient dies from asphyxia.

By way of describing the signs and symptoms of meningitis, there is very little we can add after ten centuries.

Surgery was also included in the curriculum. In some hospitals students took all the courses and later specialized under famous specialists. In others they specialized while in clinical training. It should be kept in mind that specialization was not new in this period of Islam; it probably even preceded general medicine. As in Egypt, Babylon and also India, specialists had long been on the scene.⁵

Many surgical procedures such as amputations and excision of varicose veins and of hemorrhoids were required knowledge, according to Elgood. Orthopedics was widely taught, and the use of plaster of paris for casts following reduction of fractures was routinely shown to students. It was not until 1852 that this method of treating fractures was rediscovered.

Ophthalmology was of great importance; however, little instruction was offered in regular medical schools. Apprenticeship to an eye doctor was the preferred way of specializing in this field. Operations for

cataracts were common.25

Obstetrics was almost unknown to medical schools and practice was almost completely limited to midwives. Also, minor surgery was relegated to barbers.

Consultation among medical colleagues and specialists was popular. When a patient with dropsy was admitted to the medical ward of Qalaun Hospital in Cairo, surgeons were consulted.¹⁵

It is interesting that some teaching of psychotherapy was offered and in some places required. Ibn Sina and Rhazi both widely practiced and taught psychotherapy.

And so, finally, the young physician completed his training and was ready to enter practice. However, he had another step to take: he had to undergo the licensure examination.

Licensure

Licensure began in Jundi-Shapur and was later abandoned until the tenth century. when in Baghdad, Caliph Al-Muqadir learned that a patient had died as the result of a physician's error. He therefore ordered his chief physician, Sinan-ibn Thabit bin Qurra to examine all those who practiced the art of healing.15 The total number of those examined in Baghdad alone for the first year of the decree was 800.16 From that time on, licensing examinations were required and administered in various places. Licensing boards were set up under a governmental official called Muhtasib, or inspector gen-The chief physician gave oral and practical examinations, and if the student was successful, the Muhtasib administered the Hippocratic oath and issued a license.10

Separate licenses were granted in medicine, surgery, and ophthalmology. Possession of a license was a prerequisite of good hospital appointments, particularly those with a teaching position.

Influence on Western Medicine

Such was the lot of the medical student from Jundi-Shapur to Cairo. However, the story does not end here, because for centuries to come medical education—this time in Europe—followed the foregoing pattern.

While Ibn Sina still lived, Europe was

waking from five centuries of sleep and superstition, and she awoke thirsty for knowledge. Constantine, the African, wandered through the world of Islam, and with his acquired learning settled at Monte Casino and there set about translating Arabic works into Latin. At the medical school at Salerno, and through the endeavors of such men as Gerbert of Aurillac—or as he later became Pope Sylvester II—the knowledge of the East began to be disseminated throughout Western Europe. The Crusades followed and greatly increased the contacts between Europe and the Orient. And so the cycle was completed.

According to Temkin, three events affected the form of Western medical education in the Middle Ages: the rise of urbanization, the organization of universities, and the translations of medical works from Arabic into Latin.³

As late as the fourteenth century most of Europe's physicians and surgeons were not university-trained; for example, Ambroise Pare.²⁸ With rise of the universities in Europe, Islamic science was industriously sought, and formed a large part of the curriculum of the universities of Palermo, Montpellier, Bologna, Padua, Paris, and Oxford.¹⁸

In medieval medical studies the dominance of the Islamic teachings was striking. In Montpellier and Salerno, medicine and surgery were at first taught theoretically, then practical instruction by Islamic methods was introduced. The course of study was divided into three years of premedical work, mostly logic, followed by five years of medical training in Hippocrates and Ibn Sina.³ Even as late as the fifteenth century, Islamic teachings dominated medical education in Europe.

At that time the medical curriculum at the University of Leipzig School of Medicine was devoted to the first and fourth *Canons* of Ibn Sina, the ninth book of *Continens* of Rhazi, the *Ars Parva* of Galen, and the *Prognosticon* and *Aphorisms* of Hippocrates.

In 1467 special lectures were given in many schools on Rhazi's Liber al-Monsorum;

and in the Ferrari family's medical text book, published in 1471 and very popular at this time—Ibn Sina is quoted more than three thousand times, Rhazi and Galen one thousand times each, while Hippocrates is quoted only 140 times. The Tubingen medical school taught Islamic authors up to the sixteenth century, while in the University of Louvain, as late as 1650, the works of Ibn Ṣina and Rhazi formed the basis for medical education. Even in the eighteenth and early nineteenth centuries, students at the Sorbonne could not graduate without reading Ibn Sina's Canon.

Conclusion

On reviewing the story of medical education in Islam and perusing annals of the numerous teaching hospitals of those days, I have formed certain impressions and arrived at the following conclusions:

There is little doubt that the single most important factor in the rise and exceptional quality of medical education throughout Islam, and later in Europe, was the school at Jundi-Shapur. Its immense importance lies in the practical instruction in medicine imparted to its students and in the translation and preservation of ancient medical writings. This school was thus the instrument by which Greek-based medicine was introduced in Baghdad, whence it spread throughout all Islam, and finally was reinfused into the stream of Western medical development in the late Middle Ages. Thus Islamic medicine, born at Jundi-Shapur and fed on Western ideas after several centuries of cultivation in the East, was returned to the West. In recognizing the excellence of Islamic medical education, we are not only looking at some interesting historical facts, but also acknowledging one of the main cultural links in history between East and West.

Sir William Osler, while addressing medical students, once said:

Students of Medicine, Apprentices of the Guild, with whom are the promises, and in whom center our hopes, let me congratulate you on the choice of calling which offers a combination of intellectual and moral interests found in no other profession, and not met

with at all in the common pursuits of life, a combination which, in the words of Dr. James Paget, "offers the most complete and constant union of those three qualities which have the greatest charm for pure and active minds, novelty, utility and charity." 30

The teachers and students of medicine in ancient Persia and Islam exemplified the ideals so eloquently expressed by Sir William, and to their memory I dedicate this paper to the medical students of today.

(References on Request)

Report on Trauma

EARLY MANAGEMENT OF THE CRUSHED CHEST

The so-called crushed chest is most frequently seen in automobile accident victims who are thrown against the steering wheel but may occur following any blunt injury to the chest. Multiple rib fractures produce an instability of the chest wall resulting in paradoxical respiratory movements. This is frequently accompained by traumatic pneumothorax and/or hemothorax.

The early management of this injury is directed toward:

- (1) Maintenance of an open airway.
- (2) Stabilization of chest wall.
- (3) Complete expansion of both lungs.

These resuscitative measures should be done in the acutely ill patient before undertaking x-rays and other investigative studies as the need for these measures can be determined by clinical signs alone.

- 1. Maintenance of an open airway is most surely accomplished by tracheotomy, best done through a median longitudinal incision in emergencies. Tracheotomy not only overcomes the resistance and dead space problems in the oropharynx but also allows for aspiration of the tracheobronchial tree with catheter suction.*
 - 2. Stabilization of the chest wall is help-

Fourth in a series of articles by the Committee on Trauma, North Carolina Chapter, American College of Surgeons.

Reprinted by request.

^{*} See previous article on Tracheotomy.

ed considerably by the above mentioned tracheotomy. The pain of the rib fractures is reduced by multiple intercostal nerve blocks with xylocaine. These blocks are repeated as frequently as necessary and can be complemented by the judicious use of morphine given intravenously in small doses. Such relief of chest wall pain diminishes paradoxical movement and also allows for more adequate cough and ventilation. Rarely is external suspension of the sternum with wires or towel clips necessary if the above measures are carried out. There is no place for adhesive strapping of the crushed chest.

3. Complete expansion of both lungs must be assured at all times. Hemothorax is treated by needle aspiration of the blood. If necessary this blood can be collected (in the acute phase) in citrate bottles and used for autotransfusion. Pneumothorax can be controlled with needle aspiration immediately but is beter managed by insertion of an intercostal catheter which is conected to an underwater seal.*

Once these resuscitative measures are done, a chest x-ray is taken to evaluate further the intrathoracic situation. Other injuries associated with crushed chest to be considered are myocardial contusion, ruptured spleen or liver, and traumatic diaphragmatic hernia. All but the myocardial contusion require surgical correction.

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^{*} See previous article on Pneumothorax.

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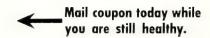
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THE MAY MEETING

When the Society gathers in Asheville this year, it may come to be remembered as the last meeting B.M. (Before Medicare). Like a lot of momentous events in our lives, it is likely that the full impact of Medicare on patterns of medical practice will take years to register on our consciousness. However, it will not be for lack of information about probable trends. The American Medical Association and the Medical Society of the State of North Carolina are hard at work analyzing and interpreting the legislation and the ways in which it is to be administered. At Asheville much of this work will be in evidence. In conversations with

friends and Society officers, one cannot help but readily get the "feel" of what is happening in a better way than that offered by reading. When a varied and instructive scientific program and numerous social events are added to all that, what more could one ask of a meeting? We hope to see you all in the mountains.

COMPROMISE ROAD AHEAD

Dr. Cadmus provided the radiologists with a good deal of straight talk when he accepted their invitation to do just that in his speech at Southern Pines. Since the points he makes are in many cases applicable to the practice of medicine in general, our readers should find his thoughts provocative and ought to ponder what he has to say.

He tells us that third-party participation in paying medical fees will soon become universal, since the public wants it that way and is not going to listen to physician's complaints about the matter. With the courts holding hospitals responsible for the standards of medical practice within their walls, surgeons as well as hospital-based specialists are soon going to be under similar conditions of practice. The surgeon who today enjoys the troubles of the radiologist and pathologist is in the position of the man whose ox is about to be gored.

In Dr. Cadmus's opinion, this country is not following the British route to a National Health Service, but is following the wish of society that everyone have health insurance. If a person or his employer does not provide such insurance, the Federal Government will. He also emphasizes that at present the government has tried to keep out of the state-level administration of the Medicare Bill as much as possible, by designating intermediaries within the states to administer its two sections, and by refusing to issue blanket rules about how physicians and hospitals should work out their relationships.

The radiologists also got some imagemolding advice, and that in good style. Dr. Cadmus tells us that patients are not going to get much, if any, impression of what hospital-based physicians do for them by how they are billed. In many cases, they won't even see the bill. They will get their impression, as patients have since the dawn of history, from the way that the physican renders his service. What does not go back so far is the impression the physician makes on the third-party agencies. This will depend on the way in which we complete the paper work, and by the degree to which they judge our fees to be "reasonable."

The Medical Society of the State of North Carolina has been temperate and middle-roadish in its responses to changing times in medicine. One of the reasons has been a willingness to compromise, which seems to exist within the Society. Dr. Cadmus calls such a willingness the sign of maturity in interpersonal relationships. When we deal in such matters we are dealing in politics, and politics has been called the art of compromise. Let's be politic.

THE FAMILIES OF LEUKEMIC CHILDREN

* * *

Oakley's interviews with the parents of fifteen leukemic children, together with a discussion of his findings and those of others interested in the same field, makes a very provocative article, yet one that many may find hard to come to grips with. Most physicians, it has been shown, are more afraid of death and more anxious about it than are members of the general public. While this is understandable, knowing that we have such fear should lead us to overcome it when, as Oakley points out, patients need us as the final hour approaches. The physician may feel that all has been done that can be done, but unless he stands by he has not done all he should do, for he is not just treating the disease but the person who has it, and his loved ones.

There seems to be a hint of guilt connected with illness in all societies, and recognition of this factor is important in dealing with the parents of leukemic children. Whether they ask the question or not, someone should tell these unfortunate people that there is nothing that they could have done,

or could have avoided doing, that would have prevented the development of the disease. Throughout the illness, the physician must prepare the parents not only for the death of the child, but for the months and years of doubts and despair that follow for so many of them. Similar avoidance of future doubts is aided by holding out the hope that research may bring more lasting relief or even cure, and thereby preventing the development of a "better-off-dead" attitude that would be a potent source of guilt in later times.

Unpleasant as the subject of death is, most physicians are intimately concerned with it, and their patients have every right to expect a realistic attitude toward it from them. Oakley's paper provides help toward achieving such an attitude.

ARAB MEDICINE

Today the general impression of the countries under Islam's sway is that of underdevelopment and reaction. That this was not always so is apparent to anyone familiar with history, and the importance of those earlier times to medicine is the burden of Dr. Podgorny's paper, now completing its appearance in this Journal. A native of Iran who came to this country to go to college and medical school, Dr. Podgorny is well-equipped to deal with the subject, since he has read the Persian manuscripts and other works in Arabic, and can relate the material to the fruits of Islamic scholarship of recent years.

During the long period when intellectual inquiry was difficult in Europe, known now as the Dark Ages, medicine was frozen in its tracks in large measure, and to doubt Galen's words was close to heresy. During these years the countries of Islam seized gratefully upon the Greek and Roman texts, and added to them their own touch of genius. Their contributions in science were many, and in medicine the names of Rhazes and Avicenna will always be highly regarded.

As one reads Dr. Podgorny's paper the scope of Islamic medical interest becomes apparent, and one is impressed by the money

and patronage lavished on things medical by the rulers of the countries involved. One is also reminded that it is the political atmosphere that sets the pace for things that happen in every reach of society. It was not a lack of inquiring minds or ideas that made Europe barren in medicine while Islam moved ahead. The difference between the two cultures was political. We must never fail to appreciate this point if we want to see medicine develop as rapidly as its potential allows.

The President's Page

YOUR INSTITUTE FOR BIOMEDICAL RESEARCH

Most of you, as members of the Medical Society of the State of North Carolina, are members of the American Medical Association. Through the AMA's Education and Research Foundation a new Institute for Biomedical Research has been established. This institute is housed in the upper three floors of the fine nine-story AMA headquarters addition in Chicago. As member scientists are recruited, specific equipment and supplies will be brought in to satisfy their research needs. The Institute is designed to provide maximum opportunity for outstanding scientists to devote their full energies to basic research in cellular biology without the distractions of teaching or performing administrative chores.

There are presently five scientists at work in the Institute, and several more are expected to join them within the next year. Plans call for a maximum of about 25 to be accommodated by the Institute. The Director is Dr. Roy E. Ritts, Jr., who will continue his own studies of the cellular mechanisms of delayed-type hypersensitivity, and his work with endotoxins, as well as directing the over-all activities of the Institute.

This writer confesses to many misgivings on becoming aware of the AMA-ERF plan to establish an Institute for Biomedical Research. Universities, foundations, and established institutes, already had facilities and supporting funds to carry out such programs. None of these, however, had the unified support of organized medicine in sponsoring medical research which is the backbone of medical practice. It is now recognized that only with broad, collective, and individual support can the ultimate goals of this program be attained. Only through

new advances in research can the tools and techniques of practice be improved.

The research to be carried out at the Institute of Biomedical Research is of a very basic kind. The Institute scientists are trying to understand the inner workings of the living cell, actually to find the common denominators of the life process and their aberrations which we know as disease.

Of particular importance is the need for independence and creative objectivity to make this research most productive. Because the Institute is being financed solely by private funds, its scientists will be under no pressure to push through crash programs or someone's pet projects; they will not have to divert their attention from their work to fill out forms and write frequent reports; and the disposition of the results of their research will be free from any and all political influence.

To finance the Institute, appeals are being made to all physicians of the United States for voluntary contributions. At the same time private industry and other foundations, many of whom are already giving generously, are being encouraged to give support. Significantly, the financing will be through AMA-ERF, not through the AMA budget.

Every member of the profession can rightfully take pride in this, medicine's own research program. It is not too little to ask that you now share in this pride by contributing to the Institute's support.

Your AMA-Education and Research Foundation is currently engaged in six additional projects which are making significant impacts. Briefly they are:

Funds for Medical Schools—This is the oldest of the programs, and the one for

which this Foundation's predecessor, the American Medical Education Fund, was established. The purpose of the program is to supply funds annually for the unrestricted use of the deans of America's medical schools.

The Loan Guarantee Program—Since its inception in 1962, the program has made possible 22,602 loans with a value of more than \$30 million to medical students, interns, and residents. A Loan Guarantee Fund coming from physicians and their organizations and private industry, is nearing the point of becoming a self-sustaining, revolving fund. There are less than 3/10 of 1% in default. About 8,000 loans were made during each of the past three years. Gifts from private industry have been instrumental in making this program possible.

The Research Project on Tobacco and Health—This project was born of a concern about the problems of smoking and health. Initially the AMA allocated \$500,000 to launch the project. Later, six major tobacco companies pledged \$10 million over a five-year period, without restrictions of any kind. Studies in this area are being pursued.

The Program of Medical Journalism, organized this year, is designed to create the

skilled manpower to meet the increasing demand for effective medical communication.

The Categorical Research Grants Program was established to accommodate those who seek an efficient vehicle to make contributions through bequests or gifts to medical research. By this mechanism small contributions which by themselves would be inadequate to support even a minor study or research effort can be accepted.

Bequest to Medical Research—A Handbook has been prepared which describes the nature of medical research and suggests how to select beneficiaries. It is distributed principally to large law firms and trust officers of banks, but is available to any physician on request.

Continuing growth and change is essential to the service of medical education and research. As needs are identified, the Foundation adopts new programs, and as needs are fulfilled, programs are retired. An unending and an ever-widening need is that of individual physician support. Even in five years the Foundation has demonstrated its value and effectiveness. Let each of us give it the liberal suport it merits.

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Correction and Apology

(The following letter from Mr. James T. Barnes is published for the information of JOURNAL readers.—Editor)

Honorable Archibald B. Roosevelt c/o Veritas Foundation West Sayville, New York

Dear Mr. Roosevelt:

This letter is written for the dual purpose of recognizing the situation of errata and of conveying to you for myself and the Medical Society the most abject apology for the situation of errata.

I will explain by saying that during the Annual Meeting of the House of Delegates of the Medical Society of the State of North Carolina conducted in Charlotte, N. C., on the 2nd of May, 1965, our distinguished Paul F. Whitaker, M.D., of Kinston, N. C., a delegate at large by virtue of being past president of the Medical Society of the State of North Carolina was speaking to a motion amending the Constitution and By-Laws of the State Medical Society so as to permit active membership in the Society on the part of any qualified Negro physician. In the course of Dr. Whitaker's speaking, he made the following reference; "I quote one paragraph from the book of Mr. Archibald B. Roosevelt, son of Presi-Theodore Roosevelt, distinguished soldier and citizen, and Mr. Sigmund Dobbs, Research Director of the Veritas Association, entitled 'The Great Deceit'." In the reporter's transcript of the above reference by Dr. Whitaker, Dr. Whitaker was erroneously reported by the official reporter to have said "distinguished socialist and citizen" with following reference to your name which of course is errata. Unfortunately, this reporter's error was not caught in the briefed transactions of the One Hundred Eleventh Annual Session of the State Medical Society and so appeared in the printed edition in error at line 17 of page 91 of the 1965 Transactions.

We pledge the efforts of this office in

rectifying this error in print in so far as it is humanly possible to do so.

It will be gracious of you to acknowledge this expression of apology and in so doing, we would request that you send a copy of same to Dr. Paul F. Whitaker, 1205 North Queen Street, Kinston, North Carolina.

With kindest regards, I am

Sincerely yours, James T. Barnes Executive Director

Bulletin Board

Coming Meetings

North Carolina Heart Association, 17th Annual Meeting—Hotel Jack Tar, Durham, May 18, 19.

American College of Physicians, Postgraduate Course on Neurology for the Internist—Hotel Robert E. Lee, Winston-Salem, June 16-17.

State Medical Society Committee Advisory to Marriage Counseling, Symposium on Sexual Problems in Medical Practice—N. C. Memorial Hospital and Carolina Inn, Chapel Hill, May 21-22.

Tri-State Medical Association, Annual Meeting—Carolinian Hotel, Nags Head, June 27-29.

New Hanover County Medical Symposium—Blockade Runner Hotel, Wrightsville Beach, August 12-13.

North Carolina Association for Retarded Children Meeting—Jacksonville, September 16-17.

Charlotte Postgraduate Seminar—Presbyterian Hospital, Charlotte, September 21-22.

Forsyth County Heart Symposium—Winston-Salem, September 30.

North Carolina Pediatrics Society Annual Meeting—Mid Pines Club and Golfotel, Southern Pines, November 4-5.

NEW MEMBERS OF THE STATE SOCIETY

Drs. James Ray Israel, GP, 900 Ninth St., Lillington; William Bark Grine, 1113 Ensworth Rd., Wilson; James Bunyan Glover, 629 Trinity Dr., Wilson; Frank Noble Sulivan, 603 E. Nash St., Wilson; Eddie P. Stiles, Box 366, Apex; Clyde Harold Steffee, Jr., Box 2000, Fayetteville; Robert Carr Moffatt, 314 Doctors Bldg., Asheville; E. Zeno Edwards, Box 227, Shelby.;

Also Drs. Philip Wiliam Warga, Cape Fear Valley Hosp., Fayetteville; Ernest Wilson Staub, Pinehurst Surgical Clinic, Pinehurst; Alfred Harris Yongue, P, 601 E. 5th St., Greenville; Joseph Louis Murad, ObG, 1730 W. 5th St. Ext., Greenville; Edward James Miller, GP, Route 1, Jefferson;

John Rudolph Fry, 309 Drs. Bldg., Asheville; Stephen T. Gupton, 912 Dwire Rd., Raleigh; Elizabeth P. Kanof, D, 1300 St. Mary's St., Raleigh;

Also Drs. Ronald H. Levine, PH, 2404 White Oak Rd., Raleigh; W. C. Deskins, GP, 1404 E. Franklin, Monroe; J. L. Taylor, GP, 1404 E. Franklin, Monroe; James David Trader, I, 2011 Chelsea Lane, Greensboro; Donald Frank Cone, R, 305 Kemp Rd. W., Greensboro; Andrew Johnson Courts, P, 914 N. Elm St., Greensboro; Calvin Haines Norman, Jr., 1051 Rich Ave., Winston-Salem; James Horace Merriam Thorp, ObG, 1256 Ft. Bragg Rd., Fayetteville;

Also Drs. Sydney Fitz Clarence Barnwell, S, 1709 Lincoln St., New Bern; E. Kent Carney, S, 210 Grover St., Shelby; Robert Grist Sumner, I, Concord; Wiliam Adlai Robie, Pd, 5437 Thayer Dr., Raleigh; Marcelino Amaya, P, 501 Central Ave., Butner; George Greene Ellis, Box 216, Old Fort; Judith Salle Yongue, GP, 601 E. 5th St., Greenville; Frank Barkley Sellers, Or, 609 Kannapolis Hwy., Concord;

Also Drs. Joel Arnold Clark, Jr., U, New Bern Dr's Bldg., New Bern; Frank Stedman Shaw, Pd, 1606 Morganton Rd., Fayetteville; William Hill Cherry, Jr., ObG, 709 W. End Ave., Statesville; Hardin Bland Griggsby, ObG, 503 E. Statesville Ave., Mooresville; Jerome H. Brodish, S, 404 N. Holly St., Siler City; Richard Carroll Neale, Jr., 105 E. 3rd St., Leaksville; James H. Davis, S, 109 Ramblewood Rr., Raleigh; William M. Ginn, Jr., I, 800 St. Mary's St., Raleigh;

Also Drs. H. W. Conran, NP, Box 1360, Goldsboro; Sam Robinson, S, 810 W. King St., Kings Mountain; Flotilla Watkins, S, Route 10, Box 583-A, Greensboro; James Morris Croft, 410 E. Concord St., Morganton; Thomas Richard Giblin, Pl, 1012 Kings Dr., Charlotte; Jack Donald Summerlin, ALR, 1350 Kings Dr., Charlotte; Amos Ray Evans, GP, 121 W. Power St., Ayden; Jackson Vance Scott, GP, Rankin St., Mt. Holly.

NORTH CAROLINA ASSOCIATION OF PROFESSIONS

William W. Dodge, III, A.I.A. of Raleigh was elected president of the North Carolina Association of Professions last week in Winston-Salem. Dodge succeeds Earl L. Knox, D.V.M., of Raleigh following the Annual Meeting held on March 9. Serving with Dodge as officers are: John S. Rhodes, M.D., first vice president; W. J. Smith of Chapel Hill as second vice president; Edward G. Batte, D.V.M. of North Carolina State University at Raleigh as secretary; and Robert G. Bourne, P.E. was reelected treasurer of the organization.

The Association of Professions is composed of state memberships representing medicine, architecture, professional engineers, veterinary medicine, and pharmacy. The state group was formed by charter in December, 1962. Thomas E. Cooke,

P. E. of Durham served as its first president, followed by John R. Kernodle, M. D., of Burlington as second president, and Dr. Knox has just compleed his office as president for 1965-1966. Dodge will serve as its fourth president for 1966-1967.

Special recognition was given John R. Kernodle, M.D., at the meeting last week when the Association presented him with a certificate of appreciation. "This was in recognition," said W. J. Smith, in presenting the award, "for Dr. Kernodle's leadership in getting North Carolina professional groups interested in an Association of Professions and getting the state to be the fifth in the nation to officially organize." Michigan was the first state to have an Association, chartered in 1958.

Awards were also presented to the three pastpresidents for their active interest and leadership in expanding the Association's membership and scope of activities.

Mr. John S. Forsythe, Chief Counsel for the Senate Committee on Labor and Public Welfare, Washington, D. C. was the key-note speaker for the Winston-Salem meeting. He spoke on expanded opportunities for training and practice in the chosen professional fields and cited the acute shortages of such trained persons in North Carolina and throughout the nation.

Claude U. Paoloni, director of Pharmacy-Central Supply, at the Moses H. Cone Memorial Hospital in Greensboro, served as moderator for the afternoon panel discussing training programs in North Carolina and entrance requirements for selected career fields.

As follow-up to the state-wide meeting last week, Paoloni announced that the Association of Professions would sponsor two programs for Community Colleges this spring on recruitment and training for professional and technical assistants. These were scheduled to be held at Southeastern Community College in Chadbourn-Whiteville area on March 17 and in Southern Pines at the Sandhills Community College on April 19.

"A third program was scheduled for the Central Piedmont Community College for March, but has been postponed until fall," said president Dodge.

Symposium on "The Young Marriage"

"The Young Marriage" will be the theme of a Symposium on Sexual Problems in Medical Practice scheduled to be held in Chapel Hill on Saturday and Sunday, May 21-22, 1966 in the Clinic Auditorium of N. C. Memorial Hospital and at Carolina Inn.

The Symposium is being sponsored by the State Medical Society Committee Advisory to Marriage Counseling with Dr. Rachel D. Davis of Kinston, Chairman.

Symposium participants will include Dr. Clark E. Vincent, Dr. Martin Goldberg, Dr. Eugene B. Linton, Dr. Lucy Jessner, Dr. Doris A. Howell, and Dr. Richard H. Klemer. Additional program details are expected to be disseminated at a later date.

NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Three fellowships, each valued at \$10,000 plus tuition and fees, have been awarded to University of North Carolina students who will enter medical school next fall.

The recipients are the first selected for Morehead Fellowships in Medicine under a new program supported by the John Motley Morehead Foundation.

Named as the first Morehead Medical Fellows are William Jarvis Busby, son of Mr. and Mrs. Max J. Busby of Salisbury; John Richard Leonard, III, son of Mr. and Mrs. John R. Leonard, Jr. of Lexington; and George Motley Oliver, Jr., son of Mr. and Mrs. George M. Oliver of Cary.

They were selected on the basis of their scholastic ability and attainments, personal qualifications, and motivation toward medicine and promise of distinction in the field.

The value of a Morehead Medical Fellowship is \$2,500 a year for each of the four years of medical school. In addition, the Morehead Foundation pays tuition and fees.

Dr. Charles E. Flowers, Jr., professor of obstetrics and gynecology and a faculty member at the University of North Carolina School of Medicine since 1953, has accepted a position in Houston, Texas.

He will become professor and chairman of the Department of Obstetrics and Gynecology at Baylor University College of Medicine beginning July 1.

Dr. Flowers came to Chapel Hill from the State University of New York after two years on the medical faculty there. He has also held a teaching position in obstetrics and gynecology at Johns Hopkins University.

A native of Zebulon, Dr. Flowers has been a consultant to the National Institutes of Health and the U. S. Children's Bureau. He has served as chairman of a special committee on anesthesia and analgesia for the American College of Obstetricians and Gynecologists and has been an associate examiner for the American Board of Obstetricians and Gynecologists.

He received the Distinguished Service Plaque of United Cerebral Palsy of North Carolina in 1964 and a similar honor from the N. C. Division of the American Cancer Society in 1959.

For a service program he developed for cancer patients in North Carolina, Dr. Flowers received a special citation in 1958 from the National Division of the American Cancer Society.

Ten of the 34 new members elected to the Southern Society for Clinical Investigation are on the medical faculty at the University of North Carolina in Chapel Hill.

They are: Dr. William B. Blythe, Dr. Kenneth M. Brinkhous, Dr. William J. Cromartie, Dr. Harold J. Fallon, Dr. C. C. Fordham, III, Dr. John B. Graham, Dr. Morris A. Lipton, Dr. Joseph S. Pagano, Dr. Harold R. Robert, and Dr. J. K. Spitznagel.

A man who thinks the federal government should do more in the field of family planning was the speaker for the second Population Seminar at the University of North Carolina in Chapel Hill.

Dr. Philip Randolph Lee, appointed last October as assistant secretary for health and scientific affairs in the U. S. Department of Health, Education and Welfare, spoke in Chapel Hill on February 10.

The series of population seminars is sponsored by the UNC Population Program with funds from the Conservation Foundation of New York City.

Dr. Mary Ellen Jones has joined the University of North Carolina School of Medicine as an associate professor of biochemistry.

She has been a member of the faculty in the Graduate Department of Biochemistry at Brandeis University in Waltham, Mass., since 1957. She was a Scholar of the American Cancer Society there for five years.

Also while at Brandeis, she was director of the dental training grant.

Dr. Jones is the wife of Dr. Paul I. Munson, who came to the UNC medical school from the Harvard School of Dental Medicine late last year as professor and chairman of the Department of Pharmacology.

The University of North Carolina School of Medicine has received approval of \$137,567 for the general suport of research and research training in 1966.

The application for the medical school was approved by the U. S. Surgeon General upon recommendation of the National Advisory Health Council.

General Research Support funds are used to complement rather than supplant Public Health Service awards. They are applied with the approval of the dean of the medical school "to improve the quality, content, emphasis and direction of the school's scientific programs."

A University of North Carolina heart specialist presented the Horace G. Smithy Lecture recently at the Medical College of South Carolina in Charleston.

Dr. Ernest Craige, UNC cardiologist, spoke on the detection of congenital heart disease by listening to a patient's heart with a stethoscope.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

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You might also say that all interns aren't alike, either.

Dr. Louis S. Harris, head and senior research biologist in pharmacology at the Sterling-Winthrop Research Institute at Rensselaer, N. Y., has been appointed an associate professor of pharmacology at the University of North Carolina School of Medicine in Chapel Hill.

He has been with the research institute since 1958 and for the last five years has also been a lecturer in pharmacology at Albany Medical School.

Sterling-Winthrop Research Institute is a division of Sterling Drug Co.

Dr. Harris is a native of Boston and was awarded his bachelor of arts, master of arts and doctoral degrees by Harvard University.

His major research interests are in drugs affecting the central nervous system, in pain, analgesia and drug addiction.

He was a National Science Foundation Fellow in 1954-55 and was awarded a National Institutes of Health Postdoctoral Fellowship in 1955-58.

A Greenville couple has established a new loan fund and an anonymous donor has established a scholarship fund for medical students at the University of North Carolina in Chapel Hill.

A \$1,000 gift from Dr. and Mrs. Edgar B. Jenkins of Greenville will be used to attract \$9,000 in matching federal funds.

Dr. and Mrs. Jenkins made a \$5,000 gift to the University several years ago for loans to undergraduate students in general.

The new scholarship fund, to be known as the Dr. Mark Braswell Scholarship Fund in Medicine, will be established with a \$2,000 anonymous gift.

The late Dr. Braswell of Rocky Mount was a UNC graduate in 1888. Scholarships for entering freshmen were set up in his honor beginning in 1938.

The first year, four entering freshmen received \$200 each. Last year, Braswell scholarships were awarded to 17 entering freshmen. Each scholarship was worth \$250.

Dr. Ralph W. Stacy, a bioengineer and biomathematician in the Department of Surgery at the University of North Carolina School of Medicine in Chapel Hill, has been named to the editorial board of a new professional journal, Computers and Biomedical Research.

Dr. Stacy was on the faculty at N. C. State University and Ohio State University before coming to Chapel Hill last summer.

The journal will be published in New York.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Dr. Wiliam Bechill, U. S. Commisioner on Aging, is one of a group of distinguished physicians who will participate in a symposium on The Care of the Aged May 26-27 at the Holiday Inn.

The conference, which is expected to become an annual affair, is being sponsored by Duke Medical Center's Department of Psychiatry and the Center for the Study of Aging and Human Development.

Also planning to attend the conference is a British psychiatrist renowned for his treatment of the aged, Dr. Felix Pos of Maudsley Hospital, London. Dr. Post will talk about "Disturbances in Memory and Thinking."

Dr. Barnes Woodhall, Dr. Ewald Busse, Dr. William Zung, Dr. Morton D. Bogdonoff, Dr. Charles Neville, Dr. Charles Llewellyn, Dr. George Maddox, Dr. Adriaan ((cq)) Verwoerdt, Dr. Carl Eisdorfer, Dr. Daniel Gianturce, and Professor Ray Brown, all of Duke; Dr. John Ewing, chairman of the Department of Psychiatry at the University of North Carolina; Dr. Ethel Shanas, professor of sociology and anthropology at the University of Illinois; Dr. Amos Johnson, a past president of the American Academy of General Practice; and Dr. Alvin Goldfarb of the State of New York Department of Mental Hygiene.

The committee in charge of arrangements includes Dr. Llewellyn, Dr. Eisdorfer and Dr. Gianturce.

Dr. Eugene A. Stead, Jr., of Duke University Medical Center, has been appointed editor-in-chief of Medical Times, a nationally circulated professional journal.

Dr. Stead, who received his B.S. and M.D. degrees at Emory University, is chairman of the department of medicine at Duke. He also is Florence McAlister professor of medicine.

Three appointments, one promotion, and three changes of status at Duke University Medical Center were announced recently.

Appointed to the staff are Dr. Johannes A. Kylstra, assistant professor of medicine and assistant professor of physiology; Dr. Edward Clifford, assistant professor of medical psychology; and Dr. Irwin Johnsrude, assistant professor of radiology.

The promotion has been given Dr. Milton Raben, who has been elevated from associate in radiation therapy to assistant professor of radiation therapy.

Affected by changes in status are Dr. Jack Botwinick, Dr. Herbert Crovitz and Dr. Ben W. Feather. Dr. Botwinick and Dr. Crovitz, associate professors of medical psychology in the department of psychiatry, now have been given the additional titles of lecturers in psychology. Dr. Feather, an assistant professor of psychiatry, also has been given the additional title of lecturer in psychology.

Dr. Kylstra, a native of the Dutch East Indies, came to Duke from State University of New York at Buffalo where he had been a visiting assistant professor in the Department of Physiology from 1963. He received his M.D. from the University of Leiden Medical School, Holland, and interned at the

Albany Hospital, Albany, New York. He also holds a Ph.D. in physiology from the University of Leiden.

Dr. Clifford came to Duke from the University of Colorado where he had been a research associate in the Institute of Behavioral Science for two years. Before that he was a research psychologist at the Children's Asthma Research Institute and Hospital in Denver, Colo., for about two years. He received a Ph.D. from the University of Minnesota in 1957.

Dr. Johnsrude came to Duke from St. Paul, Minn., where he had been in private practice from July, 1964. He was born in Calcutta, India, but received his education in Canada, graduating with a B.S. from the University of Saskatchewan in 1950 and with an M.D. from the University of Manitoba in 1956.

Dr. Robert Mathews, a resident in orthopedic surgery at Duke University Medical Center, has been awarded the Piedmont Orthopedic Foundation grant for research in orthopedics.

The \$1200 award is awarded from time to time to Duke orthopedic residents by the foundation which consists of former Duke orthopedic trainees.

Dr. Mathews, a native of Hertford, is the third person to receive the award, said Dr. J. Leonard Goldner, professor of orthopedic surgery. The others were Dr. Donald Ferlich and Dr. Ben Allen.

The award is intended to enable the winner to pursue a worthwhile research project—in this case, studying congenital abnormalities in the hips, knees, and feet of infants.

Caduceus is the name given to a new publication that was introduced recently by the Duke University Pre-Medical Society.

Issued free of charge to educational institutions, libraries, pre-medical students and advisors, Caduceus is being published to meet the needs of students for information and guidance in the pre-medical years. It is named for the emblem of the medical profession.

Dr. Max Woodbury, professor of bio-mathematics at Duke University Medical Center, has been appointed to the editorial board of a national professional journal and as a special consultant to the U. S. Public Health Service.

Dr. Woodbury, a nationally known mathematician and computer expert, joined the Duke staff in January, coming here from New York University where he had been professor of experimental neurology and head of the school's communication science section since 1962.

His editorial appointment is on *Computers and Biomedical Research*, and his USPHS appointment is with the Bureau of Community Health.

Also named to the editorial board is Dr. Ralph

W. Stacy, a bio-engineer and bio-mathematician at the University of North Carolina.

NEWS NOTES FROM BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. Thomas B. Clarkson, Jr., professor and director of the Department of Laboratory Animal Medicine at the Bowman Gray School of Medicine, has been elected president-elect of the American College of Laboratory Animal Medicine. He will become president of the organization in January, 1967, and will succeed Dr. Lisbeth M. Kraft, professor of laboratory animal medicine at the University of Pennsylvania.

The American College of Laboratory Animal Medicine was established in 1959 as a specialty college of the American Veterinary Medical Association. It is the certifying board for specialists in this field of veterinary medicine.

Dr. Clarkson, who has been director of the Department of Laboratory Animal Medicine at Bowman Gray since 1957, has developed a nationally recognized program for the care and use of animals in medical research and for the training of veterinarians in laboratory animal medicine. Six of his former trainees now hold academic positions and four of them are heads of animal care facilities at medical schools.

Dr. I. Meschan, professor and chairman of the Department of Radiology, was appointed recently to the International Committee of Radiological Information. The committee was established at the eleventh annual meeting of the Internatonal Congress of Radiology in Rome, Italy.

Dr. Meschan is one of 12 United States radiologists serving on the committee, which is attempting to develop a universal classification system to be used in standardizing the publication of diagnostic radiological information. The committee, composed of outstanding radiologists from 20 countries, will study various means of improving the presentation of radiological information in order to make it more useful to the practicing radiologist.

Dr. James F. Toole, professor and chairman of the Department of Neurology, is the author of a recently published booklet on "Diagnosis and Management of Stroke." The 32-page booklet has been issued by the American Heart Association. Designed to provide information to the practicing physician, it emphasizes diagnostic maneuvers which can be performed in any hospital setting.

Eight students and one faculty member at the Bowman Gray School of Medicine were installed March 8 as members of Alpha Omega Alpha, national medical honor society. DISPOSABLE UNIT DISPOSABLE UNIT DISPOSABLE UNIT P° DISPOSABLE UNIT DISPOSABLE UNIT 5P® DISPOSABLE UNIT

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Students who were tapped for AOA membership were Eugene W. Adcock III, Henderson; Elmo L. Allen, Star; David J. Goode, Winston-Salem; Joseph C. McAlhany Jr., Reevesville, S. C.; Philip R. Severy, Hendersonville; John C. Hamrick Jr., Shelby; and John W. Yarbrough, Burlington.

Dr. James A. Harrill, professor and director of the Section on Otolaryngology, was elected from the faculty.

The aims of Alpha Omega Alpha are the promotion of scholarship and research in medical schools, the encouragement of a high standard of character among medical students and graduates, and the recognition of high attainment in medical science.

Installation ceremonies were held at the annual banquet of the North Carolina Beta Chapter of Alpha Omega Alpha. Dr. Charles G. Child III, professor and chairman of the Department of Surgery at the University of Michigan Medical School, delivered the banquet address.

A \$75,000 grant has been awarded to the Bowman Gray School of Medicine and North Carolina Baptist Hospital by the Alexander and Margaret Stewart Trust, Washington, D. C., for the purchase and installation of a General Electric Theratron 80 telecobalt unit.

It will be the medical center's second cobalt machine. The first was installed in 1957.

When the new unit goes into operation—it is expected to be installed in about eight months—the medical center will be able to provide cobalt therapy for 90 to 100 patients per day.

Dr. Howard H. Bradshaw, professor and chairman of the Department of Surgery, spoke recently at two meetings in Puerto Rico. He presented papers on "Carcinoma of the Breast" and "Mechanical and Pharmacodynamics of Obstructive Pulmonary Emphysema" at a chapter meeting of the American College of Surgeons in San Juan. He also delivered a lecture on "Portal Hypertension" at a meeting of the medical society at Ponce, Puerto Rico.

Dr. I. Meschan, professor and chairman of the Department of Radiology, was Visiting Profesor of Radiology Feb. 25 at the University of Alabama Medical Center. He lectured on "Basic Anatomy and Roentgen Signs of Abnormalities of Cerebral Arteriography" and "Basic Anatomy and Renal Physiology Basic to the Radiology of the Urinary Tract."

Some 80 physicians and technological personnel from seven states attended a symposium on "Medical Diagnostic Ultrasound" Feb. 18 at the Bowman Gray School of Medicine. The course was sponsored jointly by the medical school and the Forsyth-

* * *

Stokes Chapter of National Foundation-March of Dimes.

Dr. Joseph H. Holmes, professor of medicine at the University of Colorado School of Medicine, was guest lecturer for the symposium. Bowman Gray faculty members who presented papers were Dr. A. Robert Cordell, associate professor of surgery; Dr. H. Kato, research fellow in neurology; Dr. William M. McKinney, assistant professor of neurology and symposium director; and Dr. Frederick L. Thurstone, assistant professor and director of the Department of Biomedical Engineering.

The Department of Obstetrics and Gynecology was host for a two-day visit of the Milwaukee Hospital Travel Club Feb. 18-19 at the medical center. Following an operative clinic and a tour of the medical center, eight members of the department presented papers during a scientific session.

NORTH CAROLINA HEART ASSOCIATION

Six North Carolina scientists have been awarded \$60,900 in fellowships by the American Heart Association to support research toward the conquest of heart and blood vessel diseases, Dr. Daniel T. Young, president of the North Carolina Heart Association announces.

The North Carolina fellowship awards just announced are among 153 totaling approximately \$2,100,000 made to scientists throughout the country under the national research support program of the American Heart Association and its affiliates. The awards are for the 12 months beginning July 1, 1966.

In addition to participating in the national research program of the American Heart Association, Dr. Young points out that the North Carolina Heart Association maintains its own research program under which \$100,548, already announced, has already been appropriated to North Carolina scientists for the current fiscal year. More than 40 heart researchers at Bowman Gray, Duke, and UNC medical centers are now receiving American Heart Association or North Carolina Heart Association financial support for their cardiovascular studies.

AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association has opened a Southeast regional office in Atlanta, Edwin L. Crosby, M.D., director of AHA has announced.

Joseph H. McNinch, M.D. will serve as director of the Atlanta office, Dr. Crosby said. Dr McNinch retired January 1 as Chief Medical Director of the Veterans Administration, after nearly 35 years of government service.

The Month in Washington

The Department of Health, Education and Welfare has issued strict guidelines prohibiting racial segregation in hospitals receiving money from the federal government.

The department said in a policy statement that schools, hospitals, and nursing homes must adhere to the guidelines to continue receiving federal funds under the Civil Rights Act of 1964.

Surgeon General William H. Stewart of the Public Health Service said more than 10,000 hospitals receiving federal funds had been sent new rules and compliance reports. He said such hospitals must not separate or discriminate on the basis of race or national origin in the care and treatment of patients.

The Office of Equal Health Opportunity is administratively located in the Office of the Surgeon General and will be headed by Mr. Robert M. Nash. It will employ a staff with special competencies and responsibilities in review and investigation of complaints, evaluation of complaint and compliance reports, public information activities, fiscal and statistical analysis, compliance negotiations, and development of recommendations for corrective action within the law, and will include experts in such areas as law, contracts, professional education and project grants, hospitals and nursing homes, and state and local health agencies.

An Office of Equal Health Opportunity has been set up by the PHS to monitor compliance with the Civil Rights law on behalf of all federal agencies in the health and medical fields.

Hospitals are being asked "whether patients are assigned to all rooms and facilities without regard to race, color, or national origin; whether all persons are allowed to use entrances, admission offices waiting rooms, dining areas and cafeterias, toilets and lavatories, and other service facilities; whether the hospital accepts and approves applications for staff privileges and training without regard to race, color, or national origin; and other similar questions," according to the HEW statement. "An up-to-date patient census by race must

be indicated on the questionnaire, as must a breakdown by race of physicians holding staff privileges.

The Veterans Administration is planning a three-state test of a simplified method of administering its so-called "home town" program under which eligible veterans are treated by local physicians on a fee-for-service basis.

Alabama, Indiana, and Colorado were selected for pilot programs beginning next July 1. VA officials are hopeful that they will prove so successful in four or five months that the simplified method can be used nationwide.

Under the experimental program, veterans entitled to treatment on a fee basis will receive an identification card stating the conditions for which he may be treated. Veterans then may seek treatment when they need it from doctors of individual choice. Doctors will treat the patient to the extent they believe is needed and bill the VA for "customary and usual" fees. Physicians will be asked to submit medical reports only when there is a significant change in a veteran's service-connected condition. schedule of maximum fees will be maintained confidentially, by agreement with the state medical society, and fees in excess of the maximum will be reduced. If the cost of continuous treatment is expected to exceed \$30.00 per month, prior authorization from the VA will be required.

The American Medical Association supports a legislative proposal for the federal licensing of dealers in research cats and dogs to protect such pets from theft and insure their humane care.

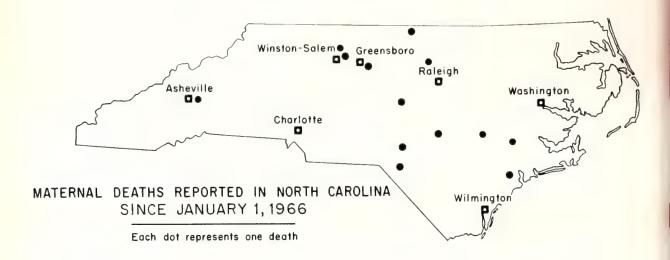
The AMA opposes licensing of research laboratories themselves and sees no need to include other research animals in such a federal program.

As for protecting research mice, rats, guinea pigs, etc., from theft, the AMA pointed out that they rarely are pets and, with few exceptions, are obtained from a few national breeding laboratories which supply genetically pure inbred strains.

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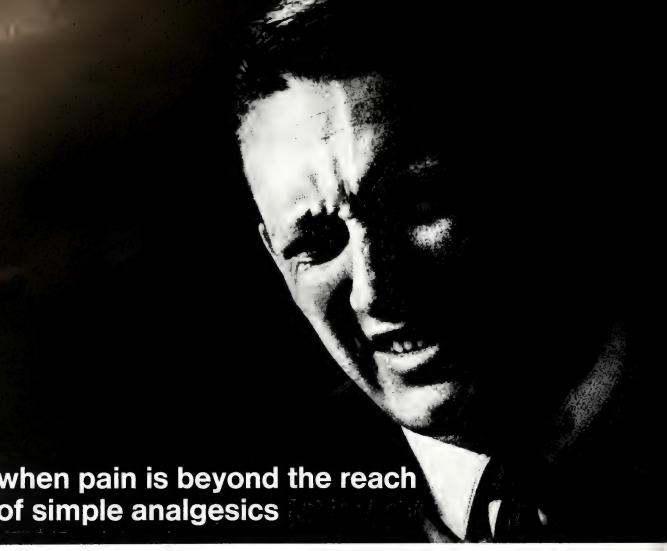
President Paschal's Farewell Address

GEORGE W. PASCHAL, IR MADO GIVE

JUN 2 1966

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NORTH CAROLINA MEDICAL JOURNAL

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VOLUME 27 NUMBER 5

ORIGINAL ARTICLES

MAY, 1966

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NORTH CAROLINA MEDICAL JOURNAL

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THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

VOLUME 27

MAY, 1966

NUMBER 5

Let Us Look To The Future Together

President's Farewell Address

GEORGE W. PASCHAL, Jr., M.D. RALEIGH

In the 35 years I have been licensed to practice medicine in North Carolina, there have been many changes which were directly related to the exercise of my privilege. The conservative Hoover administration was soon to be replaced by that of the then liberal Franklin D. Roosevelt, who in retrospect seems not so liberal. But it was the continuation of an idea which, in a series of progressions, added and expanded socialistic tendencies. In spite of resistance on the part of organized medicine and others who shared its opinion, the progressions culminated in amendments to the Social Security Act in 1965 which, many think, place the activities of the individual physician and organized medicine in a position of perpetual subjugation-if not servitude.

Moffatt translated Matthew 16:3 as, "You know how to distinguish the look of the sky, but you cannot read the signs of the times!" For more than 30 years we in medicine have known how to distinguish the look of the sky, but we are now faced with reading the signs of the times. In making such readings we find that we must look to the future—we must look to the future together. To understand and plan for the future it is fitting that we should be mindful of the past, Here, today, I shall indulge in the privilege of talking with you about certain aspects of our past, our present position, and our preparation for the future.

succeeded without the support of organized medicine. In fact, many of these programs had their genesis within the profession itself.

For more than 30 years, the American Medical Association and its component groups have opposed plans and planners that would expand the socialistic trend of the times. In spite of our efforts, which originated from a firm, conscientious feelling and were motivated by purposes of the highest principle, we watched, just last year, the end result of the democratic process to which we subscribe. A series of new laws were enacted under which we now live and

work and abide. By our participation, these

Since the founding and establishment of

the American Medical Association and the

Medical Society of the State of North Caro-

lina we have been concerned with a common

purpose to improve the quality of medical

care and the betterment of public health.

Our purpose is unchanged, but we have con-

tinually found ourselves enmeshed with the

progressive changes of our socio-economic

system. The evolution of our present system

for the distribution of health services re-

flects that so much has been accomplished,

even without any real premeditated planning,

that the world stands amazed before the un-

surpassed accomplishments which have pro-

vided for our people the highest quality of

medical care in the world today, which in-

cidentally is concomitant with the world's highest standard of living. No federal legis-

to the health fields has

lation related

Read before the Medical Society of the State of North Carolina, Asheville, North Carolina, May 3, 1966.

new laws will help open the doors to better health for all our people.

A Pattern for Progress

This has truly been termed "a dramatic year in a dramatic decade." Here in North Carolina our capacity for participation was early demonstrated, and our ability for leadership shown, in our planning and implementation of the Hill-Burton program. What was done at that time set an example of implementation which continues to redound to the credit of our state. We have seen the expansion of our Department of Public Health and the development of our state agencies, with federal support, which are bringing to many of our citizens health services that would otherwise be beyond their reach. In these endeavors the Medical Society of the State of North Carolina has been concerned, involved, and participating. Among our purposes is to provide a proper distribution of medical care, so that nothing short of the best care can be made available to any and all who might need it.

Our Society can and must play a significant role in providing these services. To do this we must have concern for the problem, become intimately involved with it, and have the broadest participation. By doing this we can help chart the course to be followed and establish a pattern for implementation which does not compromise our traditions and purposes, which maintains the time-honored doctor-patient relationship and enhances the dignity of our profession.

It is significant that many people other than physicians have recently become concerned with the health problems of our state and nation. This underscores the value which the people of this nation place on health. It further demonstrates how clearly it is recognized that personal problems of health can also be state and national problems. Almost a century ago Benjamin Disraeli, the eminent British statesman, said: "The health of the people is really the foundation upon which all happiness and all the powers of a State depend." It is no less true today.

The problems of our time have become most complex and many-faceted. These prob-

lems have been acknowledged and something is being done about them. Our federal government has embarked on programs intended to find answers.

There are programs of federal support for medical research, symbolized by the National Institutes of Health, and reaching through and beyond the NIH into every corner of the land. There are the sister programs in applied research and demonstration, also centered in the Public Health Service, but working in close cooperation with state and local health departments, schools and hospiclinics tals. and private practitioners throughout the land. We have the Hill-Burton Hospital and Medical Facilities Act, the Health Research Facilities Act, the Health Professions Educational Assistance Act. the Mental Health and Mental Retardation Act, the Medical Libraries Act, and acts in the field of Environmental Health, the last of which have particular significance for North Carolina. And now comes the one with possibly the greatest potential—the Regional Medical Programs legislation.

Our Potential for Growth

North Carolina is in an enviable position to participate in these programs by virtue of its geography, its broad educational opportunities, and the competence of the health professionals within its borders. These very assets have been responsible for our development of patterns for implementing a variety of programs in which your Society is represented and plays a major role. Our potential for expanding our services through Regional Medical Programs is beyond question of considerable magnitude. Our State Department of Public Health, with its established, operational state-wide structure, is a major resource. The School of Medicine at the University of North Carolina and its hospital form a hub which has communication with a vast number of smaller hospitals in every sector of our state. At the University is the finest of the four such schools of Public Health in the United States. We have two other first-class medical schools in Duke and Bowman Gray. Even now all of these schools of medicine have working relationships with hospitals far removed from their immediate area; and there is the prospect of a fourth medical school in the state as well.

Of no less importance as a major resource in North Carolina are the other schools and colleges scattered across our state. The state-supported colleges, the community colleges in operation and planned-for, and the many fine private senior and junior colleges, offer a broad educational opportunity for those attracted to health careers. In addition we have our technical institutes and vocational schools, without which it would be most difficult to produce the vast number of health related workers to meet the demands of our expanding population as well as the need and demand for health services.

It is with regret that I recognize that our existing diploma schools of nursing can no longer produce enough nurses to meet the demands of our times. I hope all in operation will be continued. Nevertheless, I look with some satisfaction on the action being taken in four categories to increase the number of nurses; namely, postgraduate training, baccalaureate diploma schools, and associate degree programs.

I mention these resources to draw to your attention the fact that this State does occupy a unique position by virtue of what has been accomplished in years past and by what is being done now. We in medicine like to feel that medical care is available for any of our citizens, regardless of their ability to pay. But in all frankness we must ask ourselves if there is actually an appropriate distribution of the best in medical care. From my personal understanding of the problem I must confess that I feel there can and should be improved methods for the delivery of services provided by the health professions.

Looking to the Future

This brings me to the point of looking to the future. Let us look to the future together.

Voluntary compliance

Under the provisions of many pieces of legislation in recent years, we have been allowed only an action of compliance, as evidenced in Title VI of the Civil Rights Act

of 1964. Under the provisions of Public Law 89-239 (Regional Medical Programs) we are given the privilege of participation on, and only on, a voluntary basis. While Public Law 89-97 (Medicare) will greatly affect our own way of life professionally, Public Law 89-239 has the greatest potential of all legislation in favorably affecting the care we render and our capacity to provide it. This, I again emphasize, is to be realized only upon request and upon the satisfactory demonstration of our capacity to be a part of the program within our region. It is my sincere hope that we shall provide evidence of preparedness to participate in a program which will improve medical care and provide for us, the physicians, continuing education.

Most of you are aware that your Executive Council authorized the designation of three representatives to participate on an Advisory Council charged with making a study of this significant legislation and arranging for the submission of an application to the NIH for a planning grant. This has been, or is about to be, accomplished. We are optimistic that our application will be approved.

Possibly the chief basis for our optimism is that the Medical Society and our three exceptional schools of medicine enjoy a close working relationship which is exceeded only by the unprecedented rapport which now exists between the deans of these schools and the schools themselves. In such an environment there has been developed our own voluntary program for participation in the venture of a new concept.

Role of the schools

This legislation requires that the program be oriented around one or more medical schools. A significant feature is the challenge presented to universities to develop working partnerships with area physicians and community agencies in rendering health care. The concept of "Regional Medical Programs" across the United States emerged as the dominant provision of P.L. 89-239. A total of \$340 millions was authorized over a three-year period to assist in local planning and program development. Our North Caro-

lina application carries with it a request of \$960,000 for such purposes.

In a spirit of common interest, mutual trust, and cooperative endeavor our three medical schools are bound together with the Medical Society to bring the benefits of this far-reaching legislation to the people of North Carolina, and to the health professionals who provide the service. This legislation provides for an expansion of the role of the university regarding "public service responsibility." They are being asked to develop conceptual guidelines for the development of health care programs in their regions; to carry out the necessary research to develop and test these guidelines; to catalyze the planning process through intellectual leadership; to develop some demonstrations in conjunction with other agencies; and to expand their functions in training the necessary health personnel.

The Flexner study of 1910 had a profound influence on American medicine. The background studies and public discussions attendant on the enactment of P.L. 89-239 hold a message of equal importance to universities, and especially their professional schools in the health field. It is evident that universities have a responsibility to provide postgraduate training for all members of the health professions, and a major responsibility to provide guidance for implementing comprehensive medical care programs for their surrounding communities. This idea applies to the Appalachia Regional Program as well. I think it most significant that P.L. 89-239 places heavy emphasis on local planning.

Physicians and societies

It is in this area that the individual physician and organized medicine become involved. There has been a dramatic change in recent decades in the attitude and understanding of the public about health matters. Not only is health increasingly viewed as a basic human right, but with the public's growing sophistication, there has come a steadily rising demand for comprehensive, high quality service available to all. There is an increasing public awareness that health services currently vary greatly in quality

and scope, and that the fruits of research are unevenly and imperfectly applied. Many knowledgeable people feel there is an increasing disparity between the highest medical ideals and medical performance. The individual doctor knows whether or not this is true. This program has the hope of bringing to the practicing physician ability to render care of which he need not be ashamed, but in which he might take professional and personal pride.

Need for coordination

Most of us will agree, I think, that there are major deficiencies in the organization of the health care system in this country today. It might be more appropriate to characterize it, as Dr. Henry T. Clark, Jr. says, not as single system, but as a maze of subsystems, each serving different client groups under a variety of essentially autonomous sponsors. This makes for fragmentation, duplication, or omissions in the provision of service. Under such a system probably the most important waste is in the poor use of scarce professional competence and leadership skills.

To create a single coordinated system of health care, we must move more rapidly toward the juncture of the curative and preventive aspects of medicine. These two functions can no longer be allowed to persist as separate systems of health concern. The potential exists largely within the voluntary system to create a framework within which all of our health programs can be meaningfully related. Our physicians and the community hospital have the important central role in this development.

Dr. Howard Rusk points out that authorities in medical education, research, and clinical care have long recognized and lamented the time lag between new knowledge acquired in research laboratories and its publication and application at the patient's bedside. The President's Commission on Heart Disease, Cancer and Stroke has pointed out that for every scientific breakthrough there must be a clinical follow-through. Within the last two decades there has been a tremendous volume of technological information available in clinical medicine and the

biological sciences. The problem is to keep the clinician up-to-date scientifically, and to translate such information to him in usable understandable form.

Communications

It is a happy circumstance that our technologic progress in communication has advanced as rapidly as the pace of biomedical discovery. Supplementing the traditional spoken and printed words are a vast array of new communication media, such as radio, television, motion pictures, programmed instruction, and computers.

Dr. Michael Bruno of the University of Kentucky tells us that television will afford personal communication in the same way that we use the telephone, the spoken word will be converted into print, and hospital records will soon be taken by a "picture gun" that will readily record sound and images. both still and in motion and color. Dr. Walter L. Boom of Atlanta has predicted that the medical library and physical examination of the future would not be recorded in writing, but documented by media capable of being perceived by any and all of the senses. Such media will be able to recreate its recordings. Audiovisual facilities will be established which, working with vast computer complexes, will make available push-button information for the most geographically isolated physician. Dr. Rusk further states that "if the totality of man's environment is to be utilized for his welfare, methods must be developed to make all data from the sciences and humanities available in an understandable and usable fashion."

The Regional Health Program will be a primary challenge to our teaching medical centers and to cooperating physicians on the staffs of our larger and smaller hospitals. The final mandate of P.L. 89-239 is much broader than the three diseases, heart, cancer and stroke. Dr. Henry T. Clark, Jr., feels that if this program is implemented along comprehensive lines, channels and mechanisms will be created which will provide approaches for meeting the total medical care needs of our state and nation. Its implementation should proceed through a series of steps, each of which leads toward a studied objec-

tive. It should build on existing strengths. Experimentation should be stressed, and each step should be subject to critical assessment. In this way, this program can best serve to enhance local initiative and responsibility, thereby achieving the goal of decentralizing and equalizing the state's medical capabilities.

Development of leaders

A major obstacle to the success of this program is the problem of finding and involving wise and experienced leadership in this development. Individual, interorganizational, and interprofessional differences must be moderated by the strengthening of common bonds and purposes.

The Central North Carolina Health Planning Council affords an excellent example of what can be done in other communities of our state. The local county medical societies participate in their advisory committees, hospital administrators give strength on the basis of their experience and knowledge. Bankers, insurance men, business leaders, lawyers, politicians, nurses, and others lend their talents in helping to plan to meet the health needs of the future.

There is evidence that we have outstanding leadership at the level of the university health or medical centers. There is, however, a reciprocal relationship between education for the health professions and the organization of the health care system. The individual physician, working with a health team, forms the basis for providing the health services. It is not disputed that most communities do not possess established planning mechanisms which lend themselves to the purposes of this program, but it is this very lack which brings into focus the leadership which can be expected from physicians and their local medical societies working closely with the university.

We must recruit this new type of leadership. A source for their training must be found. A plausible source for the needed staff might be through the development of postgraduate instruction programs within the newly established departments of community medicine at some schools of medicine. This would provide leaders for planning, organizing, coordinating, and administering the complex systems of health care, It would appear that the favorable towngown relationship that is presently enjoyed in North Carolina would form a sound basis for the successful implementation of this program in this state. Furthermore, additional mutual respect and understanding will follow successful collaboration.

As prospective community health centers are developed, they should hold huge potentials for the health of the people of any community. They should promote and coordinate the work of many types of health personnel and make possible the operation of the full health team. Quality of care should be high, because of the great professional and technical skills represented and because each practioner will be functioning under the observant eyes of many colleagues.

Some economies to patients should be produced by the development of community health centers within the Regional Health Program. Physicians functioning in groups, and particularly in the hospital setting, can share certain expensive equipment and technical personnel. Service to patients in this setting can be more comprehensive, which means fewer patients have to be referred to distant medical centers. Furthermore, the full activation of the community health centers will simplify the development of comprehensive, prepaid insurance programs. Also, they will provide excellent sites for educational programs for basic health personnel, as well as continuing education programs for practitioners.

It is particularly noteworthy that all these developments can and should occur within the framework of the voluntary system. Indeed, I fear, if they do not occur fairly soon within the voluntary system, that system may well not survive.

A Common Purpose

As we feel additional pressures for this and other programs arising from the apparent irreversible socio-economic trends, I would hope that organized medicine will be unified in the common purpose to provide the best of medical care and the betterment of the public health. Let us assume a role of leadership which will permit us to direct the course for the implementation of the programs that result from the will of the people as expressed in the public laws enacted by Congress. Let us heed the statement of Dr. William N. Gordon at the recent First National Congress on Ethics. He said that a doctor needs "to be ever cognizant that he is first and foremost a physician. A physician's prime allegiance is to the profession as a whole, and only secondarily to his specialty group or whatever affiliations he may have."

One final word, and this has to do with remuneration for our services. It is indicated that we shall be granted reasonable, customary, or prevailing fees. Establishing a reasonable schedule of fees for services rendered will win the acclaim of the public and enhance the image of our profession. To be unreasonable will almost certainly result in having this prerogative removed from our hands.

May God give us the capacity to "read the signs of the times." In order that we might more completely accomplish the purposes for which we are bound together, let us look to the future together.

One very common error of parents, by which they hurt the constitutions of their children, is the sending them too early to school. This is often done solely to prevent trouble. When the child is in school he needs no keeper. Thus, the schoolmaster is made the nurse, and the poor child is fixed to a seat seven or eight hours a day, which time ought to be spent in exercise and diversions. —William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 38.

Recent Advances in Intravenous Urography

SAUL BOYARSKY, M.D., PAUL E. HENSON, JR., M.D., AND JAMES F. GLENN, M.D.

DURHAM

The intravenous urogram remains the backbone of the urologic diagnostic work-up. In his time, Osler advised the young student to know syphilis because its manifestations were protean. If one knew this disease he would know all of medicine. So today we can advise the young student of urology to know the intravenous urogram because its uses are protean and he will thus learn all about urology.

Physiologic Considerations

When the kidney is presented with an excretable, radiopaque molecule in the renal arterial blood, those functions of the kidney directly concerned with the intravenous urogram are:

- 1. Renal blood flow and hemodynamics
- 2. Glomerular filtration
- 3. Tubular reabsorption
- 4. Tubular secretion
- 5. Countercurrent mechanism
- 6. Endocrine influences as they modify renal handling of fluid and electrolytes

Glomerular filtration remains the most important mode of excretion of the commonly used urographic media, Hypaque, and the other diatrizoates. Recent work has shown that the diatrizoates are excreted almost exclusively by glomerular filtration, as evidenced by their stop-flow pattern, insulin or creatinine clearance ratios, and lack of competitive inhibition. (1-4) Even diodrast is handled by glomerular filtration during intravenous urography, because the dose administered far exceeds the tubular maximum of diodrast, a drug classically used by the renal physiologist to measure tubular secretion at concentrations below tubular maximum³.

Tubular reabsorption and the countercurrent mechanism are important in their re-

From the Department of Surgery, Division of Urology, Duke University Medical Center, Durham, North Carolina.

absorption of the bulk of urinary water, sodium and other constituents from around the opaque medium, as they govern the concentration of urine and the rate of urine flow. These functions secondarily influence the degree of distention of the urinary passages, the ease of visualization, and the appearance time.

Tubular secretion may be of interest in the formation of the nephrogram or in supplying enough medium to the tubular urine to permit minimal opacification. The endocrine responses of the kidney also modify concentration and flow rates.

The renal blood flow governs the rate at which the radiopaque media is presented to the kidney parenchyma; the glomerular filtration rate is extremely sensitive to fluctuations in irregular renal blood flow. Hence the amount secreted, the rate of secretion, the appearance time, the nephrogram, the concentration of medium in the urine, and the spatial localization of the medium in the kidney are extremely dependent upon the renal circulation.

Beyond these intrarenal events culminating in the secretion of contrast medium by the nephron lie the complex events of ureteropelvic and ureteral hydrodynamics and peristalsis.

Those structures below the renal papilla concerned with the formation of the intravenous urogram are the calyces, pelves, uretero pelvic junction, ureter, ureterovesical junction, bladder, and urethra.

The calyces, pelves, and ureteropelvic junction function as a complex low pressure reservoir, which may contain a pacemaker and serves primarily to keep the terminal nephron pressure low. Although the pelvis participates in peristaltic contraction, no detrusor action has been demonstrated.

The appearance of a substance in the renal pelvis requires both secretion and the development of a sufficient concentration and amount to be visible; visibility requires, in addition to an adequate concentration, adequate volume, contrast, resolution, and light intensity. The film, x-ray tube, and the trained eye are as important as the amount of organic iodide in the line of vision of the observer.

The ureter with its characteristic peristalsis influences the renal pelvic pressure, renal pelvic emptying, and thus the function of the nephron. The runoff is intermittent and can be visualized by intravenous urograms as it is stopped. Elevations of bladder pressure due to overdistention delay the runoff from the ureter and may distend the upper urinary tract as it interferes with ureteral emptying.

Physiologic factors influencing the ureteropelvic function are the rate of urine flow, the degree of resistance or obstruction to runoff, position, extrinsic pressure, and incompetence of the ureterovesical junction. Such incompetence allows an influx of urine from the bladder by vesicoureteral reflux, leading to recirculation of urine in the upper urinary tract. In addition to a certain hydrodynamic influence from the bladder to the ureter, often as a frankly obstructive phenomenon in slowing or stopping runoff, there may be reflexes from the bladder to the kidney, such as are suggested by the phenomena of reflex anuria, responses to ureteral catheterization, and by certain experiments.7

Advances in Technique

a. Position

Changing the position of the patient is a classical maneuver to aid diagnosis during radiographic examination. The practical use of this principle has been limited only by the imagination. Demonstration of the position of ureteral or biliary calculi by combined anteroposterior and oblique or lateral films, and the use of upright films to demonstrate nephroptosis and trapping, have recently been supplemented by the use of the prone position to fill the dependent portions of the renal pelvis.8 The use of the tilting position, such as 15 degrees with the head down or the Trendelenberg position, and the alternate up and down tilting to fill the renal pelvis have received recent emphasis.9

b. Partial obstruction

As the understanding of ureteral dynamics has grown, the use of external compression, head-down tilting of the patient, and filling of the bladder has been reemphasized and advocated to delineate the upper tract more clearly.¹⁰

Elevation of bladder pressure can be achieved by filling from a reservoir at a level of 50 cm. for 5 to 20 minutes. This pressure is usually adequate to prevent the ureter from emptying during the examination. A 15-degree tilt has been proposed along with external abdominal compression to achieve the same results.

c. Premedication

The use of antihistamines to diminish the number and severity of reactions has demonstrated merit in many control studies. 11 d. *Polaroid technique*

The Polaroid technique has been advocated for intravenous urography. It requires specialized equipment which is not generally available. However, faster film may be used, requiring less exposure to irradiation. The film is available in 10 seconds. Such a technique is very useful in pyelography, preliminary scanning films, in children, as well as in determining the position of catheters and needles during manipulative procedures.¹²

e. Cinefluorography

Intensification of the image has allowed immediate visualization of the urinary tract, a more sensitive method of detecting ureterovesical reflux and a more adequate study of peristalsis. Abnormalities of peristalsis such as enlarged bolus, delay or hesitation, cystoids, dyskinesia, dissociated or ineffectual peristalsis, and retrograde peristalsis can be detected.

The rapid cassette changer has received little application in this field. The availability of 70 mm and 10 mm film for rapid sequence exposures at a frequency of 4 and possibly even 6 per second has been applied to renal arteriography.

f. Nephrograms

The intensification of the renal shadow after the injection of opaque media has been developed into an extremely useful test in which renal masses can be differentiated with a high degree of accuracy in regard to the presence or absence of functional tissue. Hence scars, cysts, and infarcts can often be demonstrated as a rarefied area, and tumors can be demonstrated as a functional area. This technique can be combined with planograms. It requires a high dosage and careful timing of the first exposures according to circulation time. The accuracy of this differentiation is limited by the "foolers" inherent in the pathology of renal cysts and tumors, which often require open inspection and histologic examination for accurate differentiation. Experience abounds with minute tumors at the base of cysts and liquefied hemorrhagic tumors with large non-functional cavitations. 13

g. Study of the urine itself after urography has been preposed as a source of useful information regarding renal concentrating operations and urine concentration. The hydrometer, refractometer, and osmometer have been used. Direct studies of the radiopacity of the urine and the specific gravity have been proposed.¹⁴

h. Radiopaque media

The development of newer opaque media by the pharmaceutical and chemical industry has achieved a new high in safety and efficiency and a diminishing incidence of adverse reactions. Recent experience with arteriography in general has demonstrated the safety of larger doses of media than had been used in previous years.

Analogy with Other Tests of Renal Function

Analysis of the many tests of renal function used today shows certain basic similarities. Setting aside the differences in the intimate handling by the nephron of the substances used, one can study the process of excretion in the (a) arterial phase, (b) parenchymal phase, and (c) ureteropelvic phase. Urographically, this is shown as the (a) arteriogram, (b) nephrogram, and (c) pyelogram or urogram.

Certain other physiologic tests are analogous to these stages: the arteriogram, the para amino hippurate clearance, the phase I of the radioactive renogram, and the electromagnetic flowmeter determination of renal

blood flow measure various aspects of renal blood flow.

The renal scan, phase II of the radioactive renogram, and the tubular maxima of glucose and creatinine measure various aspects of the functioning renal mass.

Phases II and III of the radioactive renogram and the two-hour fractional phenolsul-fonphthalein test measure the dynamics of the outflow from the kidney to the bladder. Cinefluorography of the ureter also measures this phase.

It should be pointed out that none of these is a pure test, but each is influenced, step by step, by the previous steps, and is also blurred in time or in space by overlapping of previous and succeeding steps.

It is interesting that the calculated dead space for urine below the kidney (from clearance experiments) compares quite accurately with that measured from radiographic examinations and stop-flow experiments. ^{7, 15} This volume of urine which must be emptied from the upper urinary tract before clearance determinations are accurate is that very volume which is being visualized during intravenous urography or measured during radioactive renograms.

The nephrogram and the renal scan show parenchymal uptake of their respective substances and hence outline the spatial distribution of functional parenchyma, showing the location of scars and other lesions. Obviously the specific function of the renal tissue tested and the rate of saturation and excretion after injection are quite different.

The Future of Urography

It appears that urology is moving toward a fuller and more flexible test of renal function in the development of the intravenous urogram. In a manner analogous to the study of the gastrointestinal tract by the use of barium sulfate, one can envision a patient being examined by any one or all of the following steps and precedures.

After the injection of a small amount of Hypaque, the appearance time could be noted by cinefluorography or early film taken on a rapid cassette changer or 100 mm movie strip camera. Polaroid films might serve. An allergic reaction could be ruled

out or minimized. Needless to say, a preliminary plain film or scouting of the abdomen would have been performed.

Then a conventional dose of opaque medium could be administered and its appearance visualized over each kidney and in each calyx. The transport of this material through the calyces, pelves, and ureters to the bladder could be timed for appearance, maximum concentration, and emptying.

The nature of the peristalsis and function could be observed and noted. The degree of dilatation, progression of the bolus, and the direction and normality of the bolus would be noted. Abnormality detected would include retrograde peristalsis, changes in bolus size, cystoids, to-and-fro waves, and dyskinesia.

Following this, a much larger dose could be given intravenously in combination with suitable fluids to study the nephrographic effect and even the angiogram. The nephrographic effect depends upon the dosage, rate of arterial inflow, rate of parenchymal uptake, tubular secretion, and outflow from the pelvis. Both obstruction and oliguria emphasize it. Bladder distention or possibly lowering of the blood pressure could be used to heighten this effect. The urinary tract would also be studied under the stress and distention of diuresis, thus outlining the ureters and the lower urinary tract.

Changes to the lateral, upright or tilted positions could be used to clarify certain details.

Subsequently, emptying films, a voiding cystourethrogram, and a post-voiding film would be feasible.

Obviously the technique used could be varied according to the needs of the moment. Spot films as well as accurately timed films at any interval between 10 seconds and 10 hours after injection could be taken.

The feasibility of using other media such as lead versenate or other heavy metals for allergic patients, and the determination of other aspects of renal function from external counting, urinary analysis or finer techniques of analysis of dye density, all excite the imagination.

The Minute-Sequence Pyelogram

The value of intravenous urography in the study of renal hypertension has been increased markedly by the introduction of the minute-sequence study.¹⁶⁻¹⁹

The modification of technique requiring exposures at 30 seconds, 1, 2, 3, 4, and 5 minutes, and then subsequently as in the conventional urogram, has served to refine the technique of urography to an accuracy comparable to that of most other studies for renovascular hypertension at the present time.

The demonstration of renal malfunction due to renal vascular stenosis has a two-fold purpose: (1) the detection of compromised circulation sufficient to cause hypertension, and (2) the demonstration of malfunction, which may be important in its own right.

By utilizing the appearance time and the nephrographic effect in addition to the conventional urographic phenomena of dye concentration and caliber of passages, the following abnormalities may be detected:

- 1. Diminution or asymmetry in renal size. A difference in length of greater than 1 cm is considered significant.
- 2. Absence of or delay in appearance of contrast media in a calyx or a whole renal pelvis.
 - 3. Vascular or parenchymal calcification.
- 4. Abnormal contour of renal shadow including diminution of transverse diameter.
- 5. Persistent spidering, spasticity, thinness of a calyx, infundibulum or pelvis, denoting poor filling or low flow.
- 6. Abnormality of nephrogram such as asymmetry, absence, persistence, or inhomogeneity.
- 7. Abnormalities of concentration in the calyces
 - a. Hyperconcentration
 - b. Hypoconcentration

The symmetry of urographic findings is the most important standard of diagnosis.

In many of these patients the five-minute urograms might have been interpreted as normal and the diagnosis would have been missed by the use of routine or conventional intravenous urography.

The test is simple, safe, and requires no

special equipment or preparation. Yet it provides information as refined as the more difficult tests for hypertension. It correlates exceedingly well with the radioactive renogram, with the scan, with differential function tests, and with the aortogram.

To emphasize the asymmetry of function found in the renovascular hypertension patient, two modifications have been proposed: the urea wash-out and the dehydrated-hydrated test.^{20, 21}

In the urea wash-out test, after the eightminute film has been taken, 40 gm of urea in 500 cc of saline is given intravenously. Films are taken at three-minute intervals for ten minutes and the two kidneys compared, particularly as regards density of the dye. The abnormal kidney shows hyperconcentration due to accessory reabsorption of water by the tubule. Because of the diminished renal circulation, it responds poorly to diuresis. The normal kidney responds well to diuresis and washes out, showing a diminished density of contrast medium.

In the dehydrated-hydrated test, the concentration on the affected side again remains dense, while the normal side washes out more readily after hydration.

One may wonder why the density is high in spite of poor renal circulation on the affected side. The density is not linear with function, but is actually on S-shaped curve which flattens at high concentrations. It may take several minutes or more for a poorly vascularized kidney to reach a visible density. (This may be detected early by the minute-sequence study.) Once a visible density is reached, the eye cannot differentiate this from excessive or still higher densities because the x-ray film has been bleached out of all its emulsion to whiteness.

Constant Infusion Intravenous Urography

Recent experience²²⁻²⁵ has shown the safety of large doses of Hypaque and other opaque media and has suggested that the method of intravenous urography using constant infusion has clinical merit. Present experience at the Duke University Medical Center exceeds 500 cases, and analysis of the first 100 cases is presented.

The technique of constant infusion intravenous urography requires the same preparation as conventional urography. The restriction of fluids is not necessary. An intravenous infusion of 140 to 150 cc of 50% Hypaque combined with a similar volume of 5% glucose and water or even sterile water can be utilized. The infusion is administered over three to five or eight minutes. Some have used 50 cc of a 90% solution.

The patient is observed for adverse reactions as usual. Pre-infusion testing with contrast material is necessary if this should be the first test.

Special views and positions, including nephrotomograms and planograms, are possible. Upon completion of the infusion, 2, 10-, and 20-minute films are obtained. Delayed films may be indicated.

The technique is valuable in four broad areas:

- To improve upon poor or unsatisfactory urograms, whether due to technique, poor bowel preparation, obesity, or other difficulties.
- 2. In cases of poor renal function, visualization has been reported with blood urea nitrogen levels ranging up to 100 and 120 mg/100 ml.
- 3. For delineation of anatomic detail.
 - a. To fill out calyces, pelves or ureters in normal, obstructed or pathologic organs, or to intensify in minute-sequence urogram.
 - To outline the lower tract and even in preparation for voiding cystourethrograms.
 - c. To improve the outline of the renal shadow for utilization of the nephrogram to study masses and scars.
- 4. In cases where retrograde pyelography is contraindicated or undesirable. The incidence of the retrograde pyelogram has dropped below 1% of all x-ray examinations in the experience of our services and others.

The side effects encountered are similar to those with the lower dosage—nausea, vomiting, bad taste, and flushing. One episode of unexplained fever, one convulsion, and no other serious reaction resulted. Oliguria and

multiple myeloma are serious contraindications to urography. Allergy and idiosyncrasy are also contraindications, but these must be evaluated carefully.

There has been no noticeable adverse effect following the use of this technique. Those patients with renal failure who have been followed by us and by others have shown no immediate or delayed deterioration of renal function as measured by BUN and serum creatinine. Studies of proteinuria have not yet been reported.

Toxic doses of Hypaque in animals are ten times as high as that used here. (LD∞)

Our series was categorized according to clinical value in the first 91 cases (Table 1).

Table 1

Evaluation of Constant Infusion Intravenous Urography in 91 Cases

	No. Cases
No value over conventional intravenous	
urograms	24
Significant additional information provided	18
Diagnostic where conventional urograms	
were not	17
Actuarially obviated retrograde pyelograms	32
Total	91

When combined with planograms or cinefluorography, this method develops additional value. In examining patients cinefluorographically under image intensification, it is possible to see the calyces, pelves and ureters fill, become slightly swollen and distended, and then later to empty. It is apparent from the published urogram that the collecting system can be filled completely in the normal kidney by this technique but rarely, if ever, can it be distended to the point of abnormal dilatation.

Constant infusion intravenous urography has been found to be safe, convenient and readily performed. It provides better visualization of the pathologic anatomy of the urinary tract, provides more information than do conventional techniques, and has obviated the use of retrograde pyelography in a significant number of cases. Visualization of the urinary tract becomes possible in moderate renal failure, and the incidence of side effects is no greater than with the lower dose.

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Dimethyl Sulfoxide (DMSO)

A Review of the Literature ROBERT E. WILLIAMS, JR. WINSTON-SALEM

Historical Development

Dimethyl sulfoxide (DMSO) was first synthesized and described as a chemical in 1867, but it was primarily "a laboratory curiosity" until 1948, when data on some of its physiochemical characteristics began to appear.¹

Some of its properties were found to be of commercial value, particularly its outstanding efficacy as a solvent. Some other commercial uses have been as a reactant for chemical synthesis, as an extractant, as a catalyst, and as a penetrant carrier of such agents as dyes, fungicides, and insecticides into plants.^{2, 3}

The Crown Zellerbach Corporation, a large paper-producing company in the United States, discovered and patented a method for producing DMSO economically from the waste products of paper pulp manufacture.⁴ The company began producing DMSO commercially and investigating other possible uses of the chemical. It was observed that dyes in solution with DMSO were found to penetrate even the protective synthetic rubber gloves of workers and produce temporary toxic effects through percutaneous absorption. Thus interest was aroused in DMSO as a possible penetrant carrier of dermatologic and perhaps even systemic drugs.⁵

In 1959 reports began to appear describing the effectiveness of DMSO as an antifreeze to protect mammalian cells and tissues against damage due to freezing.⁶ A few years later Stanley W. Jacob, M.D., associate professor of surgery at the University of Oregon Medical School, inquired of Robert J. Herschler about the possibility of using DMSO to protect organs against damage due to freezing prior to transplantation. Herschler, a Crown Zellerbach chemist

and supervisor of applications research of the company's chemical products division, suggested that the penetrant carrier properties of DMSO might be useful in the medical field. It was decided to conduct an experiment to determine if DMSO as a vehicle would enhance the penetration of topically applied antibiotics into burn eschars of rats and facilitate healing. For a control study DMSO alone was used, with surprising results. Quite unexpectedly it appeared to enhance healing and prolong animal survival time. A short time later DMSO was applied topically to the chemical burns of a researcher who had contacted a vesicant poison. DMSO rapidly relieved the pain and reduced the inflammation. During the ensuing weeks DMSO was used topically for a variety of painful acute musculoskeletal disorders in humans and was found to reduce pain and inflammation in these conditions.5, 7

In late 1963 the Crown Zellerbach Corporation and the Oregon State Board of Higher Education made an agreement that the University of Oregon Medical School would further explore the possible medical applications of DMSO, with all future royalties to be equally divided between the Board of Education and Crown Zellerbach.2, 5 On December 10, 1963, a news release describing the penetrant carrier property of DMSO was issued by the Department of Public Affairs at the University of Oregon. On December 18, 1963, a second news release described DMSO's possible analgesic and antiinflammatory properties.² In February, 1964, the first report of DMSO's possible medical uses appeared in a scientific publication. The possible medical uses reported in this editorial were as a penetrant carrier, a local analgesic agent, an anti-inflammatory adjunct, a bacteriostatic agent, a diuretic, a tranquilizer, and a potentiator of other compounds. Six pharmaceutical companies—American Home Products, Geigy, Merck, Schering, Squibb, and Syntex—obtained licenses from Crown Zellerbach to produce medicinal DMSO, and the FDA approved the compound as an investigational drug, although only for topical application. Hundreds of approved investigators throughout the nation began clinical studies of DMSO.

Meanwhile DMSO was being proclaimed as a panacea by the lay press. Articles describing its "miraculous" properties appeared in Saturday Evening Post, Newsweek, Time, Life, Pageant, and other magazines. Typical of the ballyhoo was the opening paragraph of an article which appeared in Life in July, 1964:

"A fantastic new experimental drug called DMSO has lately been causing a sensation in the medical world. It is hard to talk about it without sounding like an old-time carnival snake oil salesman. DMSO appears to be good for arthritis, sinusitis, headaches, earaches, sprains, and burns. It reduces swellings, suppresses blisters, kills pain, tranquilizes, fights germs. It enhances the action of other drugs. It can be swallowed or injected, rubbed on or dripped in. In a word, it is unbelievable. But some serious and respected medical scientists believe in it. If DMSO (for dimethyl sulfoxide) lives up to their expectations, it will come closer to being the legendary panacea than any drug in all medical history."4

It is hardly surprising that patients suffering from many painful chronic illnesses who could not get the pure medicinal form of DMSO were willing to try self-medication with the impure commercial-grade DMSO being sold as a solvent in paint stores. A "gray market" for DMSO developed, and it was reported that even "some physicians are known to be using commercial-grade DMSO." 10

Time reported in September, 1965, that "pain-racked arthritis victims have been paying \$3.50 an ounce for bootlegged crude commercial DMSO, which may be dangerous." The remarkable properties of DMSO which make it promising as a vehicle for drugs also make the commercial-grade compound potentially toxic when used for medical purposes, for impurities dissolved in commer-

cial-grade DMSO may be introduced into the systemic circulation when the compound is applied topically.

An editorial which appeared in the Journal of the American Medical Association in April, 1965,2 was highly critical of the manner in which the early investigators of DMSO had managed the investigations and reports of the compound. It pointed out that the investigators had found it impossible to conduct double-blind studies of the drug because of the characteristic garlic-like or oyster-like odor it produced on the breath. The JAMA also found it difficult to justify "the first major public announcement of a new drug in a news release rather than in a scientific publication." The editorial suggested that "circumstantially, at least, the course of events would seem to support a charge that the institutions involved, either actively or passively, used the studies carried out on DMSO in a manner designed to get the maximum of publicity."

Fortunately most investigators disregarded the issue concerning the manner in which the early medical reports of DMSO were handled, and subscribed to Kligman's view³ that "whether or not one judges the reports to be premature, pretentious, or merely provocative, it is the tradition of the scientific credo to settle these matters by objective inquiry, not by carping debate." Thus the hundreds of clinical investigators continued the arduous task of accumulating data from their trials of DMSO in humans.

In November, 1965, the FDA temporarily suspended the use of DMSO in humans, because the compound "caused changes in the refractive index of lenses of experimental animals." These changes were reported in dogs, rabbits, and swine in the laboratories of one English and two U.S. firms. 10 Nevertheless in approximately 18 months of clinical trials with DMSO, clinicians "have documented more than 10,000 (and possibly upward to 25,000) patients." 12

A review of some of the more important findings of 18 months of clinical investigation and of the previous years of scientific investigation of DMSO follows.

Chemical and Physical Properties

The formula for dimethyl sulfoxide is

$$\mathrm{C}\,\mathrm{H}_{_{\mathbf{3}}}\overset{\mathrm{O}}{\mathrm{S}}\,\mathrm{C}\,\mathrm{H}_{_{\mathbf{3}}}$$

The molecular weight is 78.13. It is a highly polar organic liquid and is colorless and essentially odorless in a purified state. It is miscible with water and most common organic solvents. DMSO has exceptional ionizing properties and is markedly hygroscopic in concentrated solutions. It is an organic solvent and will dissolve most aromatic and unsaturated hydrocarbons, organic nitrogen compounds, and others.

DMSO is a relatively stable compound with a melting point of 18.45 C and a boiling point of 189 C at atmospheric pressure of 760 mm of mercury. The specific gravity is 1.104 at 20 C, and the refractive index is 1.4783.^{7, 12}

Pharmacology

Following dermal application, DMSO is rapidly and nearly completely absorbed, with about 80% of the dose being absorbed in the first hour. A study of the distribution of radioactive DMSO (35S) in rats indicates rapid and wide distribution of the compound throughout all tissues of the body, with plasma levels being higher than tissue levels at all times. Little is known of the metabolism of the compound in the body except that a metabolite, dimethyl sulfone, has been recovered in the urine of rats treated with DMSO.¹³

DMSO has been demonstrated to produce a reversible change in the permeability of the stratum corneum to penetrant substances without producing any structural change. Kligman has written: "It is almost as if the penetrant is conducted through the horny-layer barrier by remaining dissolved in a continuous channel of dimethyl sulfoxide which occupies intermolecular spaces."³

The enhancement by DMSO of the absorption of other compounds through biologic membranes has been demonstrated with a wide variety of chemicals, including hexopyrronium bromide, naphazoline hydro-

chloride, fluocinolone acetonide, hydrocortisone, aminophylline, sodium heparin, insulin, Evans blue dye, Thio-TEPA, sodium sulfadiazine, sodium salicylate, barbital, morphine, chlorpromazine, and reserpine.⁸, ¹⁴⁻¹⁷ DMSO is the first relatively nontoxic solvent found that will effectively dissolve alphaglucochloralose, a hypnotic which has had limited use because of its low solubility. DMSO accelerates its onset of action without affecting its duration of action or toxicity.¹⁸ DMSO has also been reported to have a synergistic effect with insulin in lowering blood sugar levels.⁸

A reservoir of certain drugs can be attained in the skin by their topical application in combination with DMSO. DMSO has been shown to increase the retention of glucocorticosteroid by as much as 100 times for as long as 16 days. This reservoir is also resistant to cleansing with soap or alcohol.¹⁹

DMSO in a 20% solution has been found to be bacteriostatic to a variety of bacteria including Staphylococcus aureus, beta hemolytic streptococci, Escherichia coli, and Proteus species. DMSO is bactericidal to many genera of bacteria in concentrations of 30% to 40%, but a 50% concentration is required for Staph. aureus. Thus, although its antibacterial properties are weak, DMSO is "roughly comparable to many other so.vents and far inferior to alcohol."3 Some studies, however, indicate that DMSO enhances the sensitivity of resistant bacteria to antibiotics, perhaps through its penetrant carrier property.20 DMSO is a weak antifungal agent, but it is a potentially useful vehicle for other antifungal agents used in treating superficial fungal infections.3

The analgesic properties of DMSO have been well documented, ^{1, 5, 7, 12, 21-25} though one investigator was not able to demonstrate a very strong local analgesic effect in the skin.³ The mechanism by which DMSO produces analgesia is unknown, but is thought to be by means of a partial block of nerve conduction. Supporting this theory is the fact that DMSO in a 25% concentration has been shown to block nerve conduction in the laboratory.^{12, 26}

Animal Toxicity

DMSO has been demonstrated to have a rather low order of acute toxicity in a variety of laboratory animals.5, 7, 12, 27-29 The median lethal dose (LD₅₀) for a single intravenous administration in dogs is approximately 2,500 mg per kilogram of body weight. The approximate values of the LD₅₀ for acute intravenous administration in other animals range from 3,820 mg/kg to 10,730 mg/kg The acute toxicity of DMSO was appreciably less when the compound was administered to these animals by other routes. The approximate LD₅₀ (mg/kg) ranged from 12,500 to 28,300 for oral administration, from 13,900 to 25,640 for subcutaneous administration, and from approximately 5,500 to 20,060 for intraperitoneal administration.

Apparently, the exact cause of death in the animals which succumbed to the median lethal dose is not known. With intravenous administration, death was preceded by tremors, myasthenia, dyspnea, and occasionally convulsions. Oral administration of lethal doses produced ataxia, myasthenia, decreased motor activity, and bradypnea shortly after administration.²⁸ However, no specific microscopic or macroscopic evidence of toxicity has been found in any organ or tissue at autopsy of exposed animals.^{27, 29}

Studies of chronic toxicity in animals likewise indicate a low degree of chronic toxicity of DMSO.5, 7, 12, 27-29 Examples of the MTD (maximum tolerated dose in mg/kg day x days of administration) of DMSO to animals are 2,500 x 35 for oral administration to the mouse, 5,000 x 30 for the subcutaneous route in the rat, 2,500 x 35 for the intraperitoneal route in the mouse, and 4,000 x 69 for the intravenous route in the monkey. Dogs have tolerated up to 1,000 mg/kg/day topically for five days per week for 15 months without demonstrating any significant abnormalities in liver function or renal function tests, hemograms, or urinalyses.7 No hematologic, biochemical, or histopathologic changes definitely related to DMSO occurred in dogs receiving 400 mg/kg intravenously for 33 days.29 However, changes in in the refractive index of the lenses of dogs after chronic oral administration of DMSO,

and of dogs, rabbits, and swine after chronic topical application, prompted the FDA to stop clinical trials of the drug.¹⁰

Clinical Toxicity

The low degree of toxicity of DMSO in animals has been confirmed by the clinical studies of topically applied DMSO in humans. The side effects encountered have consisted almost entirely of the characteristic odor on the breath and occasionally a local or generalized dermatitis. Rosenbaum and others, reporting on a series of 548 patients, found that "the only adverse reactions requiring discontinuance of DMSO were in 39 or 7% of the patients who showed local dermatitis, generalized dermatitis, or extreme lethargy," and reported that "no serious toxicity has been encountered to date clinically in the topical use of dimethyl sulfoxide."

The most common side effect is the typical DMSO odor produced on the breath, described as oyster-like or garlic-like by most patients. This odor, which has been a major hindrance to conducting double-blind studies with the drug, is probably due to breakdown of the compound to dimethyl sulfide in the body.^{7, 30}

Kligman found that DMSO has two separate actions in producing reactions in the human skin, a histamine-liberating effect and a primary irritant effect. The histamine effect occurs during the first week or two of topical therapy but then disappears because of depletion of the mast cell stores of histamine. The histamine effect is usually manifested by a transient erythema. The irritant effect is seen as "a mild, erythematous, scaling dermatitis" in a minority of patients following daily topical application of a 90% concentration. The inflammatory change is primarily in the epidermis, and it "invariably regresses as treatment continues, the skin eventually becoming histologically normal."

In summarizing the cutaneous effects of DMSO, Kligman said, "None of the cutaneous effects produced by topically administered 90% dimethyl sulfoxide constitute a contraindication to the treatment of musculoskeletal and connective-tissue disorders." Minor cutaneous effects described

by other workers are pruritus and increased pigmentation at the site of application; but these effects, like the dermatitis, are temporary or reversible.⁷

Although clinical trials with DMSO were stopped by the FDA because of changes produced in the refractive index of the lenses of laboratory animals, similar changes have not been reported in human subjects. Goldman detected no ocular problems in 1,300 patients treated with the drug over a two-year period.³¹ Gordon reported no increase in intraocular pressure in 200 patients treated for a variety of inflammatory conditions of the eye.⁹

Investigators who have reported extensive clinical trials with DMSO in a total of more than 2,000 patients concur that the compound has no serious systemic toxicity. No significant alterations have been found in the serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, serum bilirubin, blood urea nitrogen, prothrombin time, alkaline phosphatase, serum protein values, or in the albumin-globulin ratio, platelet count, hemogram, or urinalysis.^{3, 7,} 12, 22 However, the report of a fatality following therapy with DMSO prompted two pharmaceutical companies, licensed by the FDA to test the drug in the United States, to issue cautions to clinical investigators. The woman who died apparently of an anaphylactic reaction had been receiving penicillin injections and possibly taking an antidepressant in addition to DMSO. The FDA took no action on the case since DMSO was not proved to be responsible for her death.32

Clinical Results

DMSO is certainly not the panacea promised by some of the lay publications in 1964; nevertheless its remarkable versatility is obvious from the wide variety of ills for which it has been reported to be effective.

DMSO has been found to be beneficial in treating intractable pain in surgical patients. The compound was used in the treatment of 11 patients with phantom pain, 11 patients with tic douloureux, 10 patients with post-traumatic pain, and 5 patients with postoperative pain, which in each case had persisted for at least one year despite con-

ventional therapy. In these 37 cases the average duration of intractable pain was approximately five years. Thirty-two of these patients obtained "marked pain relief" from DMSO therapy.¹²

Rosenbaum and others reported that 437 of 548 patients with various types of musculoskeletal disorders improved on receiving DMSO therapy. In acute musculoskeletal injuries, 195 of 210 patients improved, the relief of pain and muscle spasm occurring within 30 minutes and lasting 2-12 hours. Twenty-two of 25 patients with acute subacromial bursitis and 32 of 40 patients with chronic subacromial bursitis improved. The acutely affected patients showed increased range of motion and decreased pain within 30 minutes, but the chronic cases required treatment for three months for complete relief of symptoms. Eighty-eight of 110 patients with osteoarthritis improved, and 60 of 80 patients with rheumatoid arthritis classified as grades 1 and 2 improved. These patients exhibited increased range of motion and diminished pain and muscular spasm. Patients with the more severe grades 3 and 4 rheumatoid arthritis responded less dramatically to DMSO therapy, and only 30 of 70 were judged to have improved. They showed some diminution of swelling and relief of pain. Three of 5 patients with acute gouty arthritis improved, showing a decrease in redness, swelling, and pain. All three patients with Dupuytren's contracture improved, as shown by a reduction in the size of the plagues in the palmar fascia and increased range of finger motion.7 DMSO has also relieved pain in degenerative arthritis of the knee, 21, 24 and is reported to give dramatic relief of muscle spasm²³ and permit painless manipulation in cases of fractured bones of the hands or feet.5

One ophthalmologist reported that DMSO has analgesic and anti-inflammatory effects in conjunctivitis, iritis, episcleritis, uveitis, meibomitis, and blepharitis. In some cases it enhanced the effectiveness of steroids and of ocular decongestants. No increase in intra-ocular pressure resulted.⁹

Relief of the pain in patients with thrombotic external hemorrhoids by topical application of DMSO has permitted complete sigmoidoscopy without discomfort. DMSO also facilitated organization and absorption of the clots. Application of the drug to the sacrococcygeal skin in cases of painful coccygodynia relieved pain and permitted sigmoidoscopy and the manipulation of the bone and its attachments.²⁵

DMSO has inhibited necrosis of a pedicle flap in a quadriplegic who underwent surgery for a sacral decubitus ulcer. Eleven days postoperatively the DMSO-treated flap was "within normal limits," while an identical control flap had formed "a well-demarcated slough".³³

DMSO is reported to have been useful in treatment of first, second, and third degree burns, affording improved healing, pain relief, and control of Pseudomonas infections.^{5, 26} One investigator, however, reported that in his series of patients, "dimethyl sulfoxide did not materially affect the outcome in respect to (1) relief of pain, (2) suppuration, (3) time for crust formation, and (4) epithelialization and scab separation."³

Scherbel and others^{3‡} reported rapid healing of persistent ischemic ulcers of the fingertips in 5 of 6 patients with scleroderma following topical applications of DMSO. Several months later he reported that 36 of 36 scleroderma patients who had not benefited from other therapy, showed improvement in the cutaneous manifestations of the disease.¹⁰ Rosenbaum and others⁷ also reported improvement in scleroderma patients treated with DMSO.

DMSO has been reported to relieve some of the manifestations of peripheral vascular diseases, such as intermittent claudication and ischemic ulcers.⁵ Two of three patients with persistent postmastectomy lymphedema of the upper extremity showed improvement with DMSO therapy.²⁶

Herschler and Jacob⁵ reported that application of DMSO to the lesions of herpes simplex "generally effects rapid healing." The drug has also been reported to be effective against herpes zoster, and prevented pain and scarring when therapy was begun during the early acute phase.³⁵

One investigator found DMSO to be beneficial in treating psoriasis and eczema;³¹

however, another reported that it was not as effective as a steroid with occlusive dressing in the topical treatment of psoriasis. According to one report, the pruritus and discomfort of about 50% of cases of contact dermatitis from poison oak sensitization are relieved by topical DMSO therapy. 5

Comment

Not all physicians are in complete agreement with the FDA's decision to suspend clinical trials with DMSO. Commenting on the action, Dr. Albert Sjoerdsma, Chief of the Experimental Therapeutics Branch of the National Heart Institute, stated that it was unwarranted to withdraw DMSO from people with severe disease and limited life expectancy who were being helped by the drug. Dr. Dan Gordon of New York Hospital-Cornell Medical Center pointed out that the experimental animals which exhibited the lens changes on which the FDA based its decision had received 8 to 16 times the normal dose of DMSO. Many clinical investigators who have found DMSO to be beneficial to their patients without producing any evidence of toxicity are disappointed in the recall of the drug and have sent letters of protest to the FDA.¹⁰

It would certainly seem logical to suppose that the FDA will not ban a drug permanently on the basis of toxicity obtained from administration of many times the normal therapeutic dose to animals. One has only to consider what would happen to experimental animals should they be given abnormally high doses of many of our most valuable drugs in use today—steroids, antihypertensives, etc.—to see that such a policy would be absurd.

Summary

Dimethyl sulfoxide (DMSO) is a highly controversial drug which has been studied in human beings fairly extensively over a rather short period of time but currently is not available for clinical investigation due to restriction by the FDA.

Studies in laboratory animals have shown the drug to produce relatively low systemic and local toxic effects in both acute and chronic administration through several routes. However, changes which occurred in the lenses of animals receiving the drug and led to the FDA ban are being evaluated at the present time.

DMSO has been administered to human beings only by means of topical application. The drug was found to be absorbed rapidly and distributed throughout all body tissues. It reversibly increases the permeability of the stratum corneum to other substances and can induce a skin reservoir of certain drugs. Its antibacterial and antifungal properties are weak, but it enhances the sensitivity of some resistant bacteria to antibiotics and is a useful vehicle for some antifungal agents.

Side effects reported in humans have been a garlic-like or oyster-like odor on the breath, local or generalized dermatitis, lethargy, pruritus, and a localized increase in pigmentation. Death occurred in a patient receiving the drug, but DMSO was not proved to be directly responsible. Thus far no serious systemic toxic effects in humans have been reported.

DMSO has been effective in treating in-

tractable pain in surgical patients with tic douloureux, phantom pain, posttraumatic pain, and postoperative pain. Although results have varied somewhat, it has produced some remarkable analgesic and anti-inflammatory effects in the treatment of acute musculoskeletal injuries, acute and chronic subacromial bursitis, osteoarthritis, gouty arthritis, degenerative arthritis of the knee, thrombotic external hemorrhoids, and a variety of inflammatory conditions of the eye. It has also been used with some success in Dupuytren's contracture. coccygodynia, burns, postmastectomy lymphedema, herpes simplex, herpes zoster, contact dermatitis, psoriasis, and eczema. The drug also has been reported to have inhibited flap necrosis and to have been the most useful drug to date in treating scleroderma.

References on request.

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Scoliosis In Twins

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Scoliosis in twins is an unusual event, although several instances have been reported recently in the world literature¹⁻⁴. As Murdoch⁴ has pointed, the phenomenon is of some interest since, in humans, twins afford the only opportunity to study the influence of environment upon genotype.

Case Reports

The twin sisters reported here were 11 years old when first seen by a physician, and have been examined regularly by the same orthopedic surgeon for nine years. Twin A had a right dorsolumbar curve of 65 degrees, with the apex at the ninth thoracic vertebra. Twin B had a right dorsolumbar curve of 40 degrees, with the apex at the



Fig. 1. Twin A (right) and Twin B (left). Note similarity of curves.

eleventh thoracic vertebra. Each was initially treated with a turnbuckle cast and spinal fusion after maximum correction had been obtained. In Twin A fusion extended from the sixth thoracic to the second lumbar veterbra, and in Twin B from the seventh thoracic to the first lumbar vertebra. Postoperatively each twin was maintained in a brace for eight months.



Fig. 2. Twin A (right) and Twin B (left). Note similarity of facial features.

Figures 1 and 2 are recent photographs of the patients at the age of 20. Their most recent roentgenograms, taken in September, 1961, nine years after arthrodesis, are shown in Figures 3 and 4. The curves are similar, though that of Twin A is more pronounced. When clothed, both young women present a good cosmetic appearance, and both are asymptomatic. In each case, the pelvis is level, but the right shoulder is carried slightly higher than the left. The values for the curves at maturity are 65 degrees for twin A and 55 degrees for Twin B. Loss of correction occurred in each case, possibly because of inadequate length of the fused areas.

At the age of 20 Twin A is 159 cm tall and weights 51 kg. Twin B is 161 cm tall and weighs 59 kg. The color and texture of the skin and hair are identical, as are the facial features, the color of the eyes, the shape of

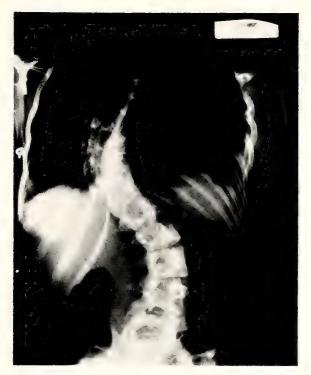


Fig. 3. Twin A. The numerical value for this curve is 65 degrees, and the apex is at the ninth thoracic vertebra.

the ears, and the patterns of hair distribution. Each twin is right-handed. For each, the major blood group is A, and the Rh typing is cDE/c?e. No anti-d serum was available.

With the exception of the scoliosis, both twins have enjoyed excellent health and have had no other illnesses requiring hospital admission. The family history reveals one normal male sibling and no remembered instances of scoliosis or other orthopedic deformity in either maternal or paternal line.

Comment

From the cases presented here and others recently reported¹⁻⁴, an hereditary predisposition to scoliosis may be inferred. However, these isolated twin studies, while adding to the body of genetic evidence, are insufficient for a complete understanding of the pattern of inheritance involved. Carter⁵, in an editorial concerning genetics in orthopedics, observed that family studies are nec-



Fig. 4. Twin B. The numerical value for this curve is 55 degrees, and the apex is at the eleventh thoracic vertebra.

essary to elicit the particular type of genetic factors which may be acting.

The mechanism by which the involved hereditary factor produces scoliosis also remains to be proved. Esteve² has listed several possible local factors, including alteration in the growth nucleus or the epiphyseal plates, disturbances in the vascularization of vertebrae, alterations in the spinal muscles or their innervations, and metabolic or endocrine disturbances.

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A History of Medicine and the Medical Society in Mecklenburg County in the Early 20th Century

WILSON K. WALLACE

WINSTON-SALEM

The earliest recorded statement concerning the formation of a medical society in Mecklenburg County appeared in the *Charlotte Observer* for October 7, 1903. It read as follows:

An organization of the Mecklenburg County Medical Society will be effected today in the Court House at 11:30 o'clock. There are sixty doctors in Mecklenburg County, and it is probable that a majority of these will attend the meeting at the Court House. It is expected that every doctor in the county will be a member of the organization.

The proposed organization, which was to be entirely separate and distinct from the Charlotte Academy of Medicine, was organized in accordance with plans adopted at the latest meeting of the Medical Society of the State of North Carolina. At that time the plan of organization was changed to make county societies components of the state organization. In joining a county society, a physician also became a member of the State Society.

The next day the *Observer* dutifully recorded the transactions of the organizational meeting, which was held at the Court House as planned, and lasted for two hours. Dr. E. C. Register presided. The time was largely devoted to the adoption of a constitution and bylaws. The greater part of the constitution was taken from the recommendations of the American Medical Association and the State Medical Society. A board of censors was also appointed at this meeting.

According to the bylaws, the officers were to compose the Committee on Program and Scientific work. Committees on Public Health and Legislation were also established. The Observer reported:

The physicians considered the meeting a success in every respect, and Doctor Register was exceedingly well pleased with the prospects of what he said would be "the most flourishing medical society in North Carolina." The meeting adjourned around 2:00, to meet again the first Monday in November.²

Thus was signalled the beginning of a medical society in the County of Mecklenburg, State of North Carolina.

Early Years

At this time the art and the science of medicine was not as sophisticated as it is today, as evidenced by the type of advertisements which were appearing in the *Observer* and other newspapers of the day. One of these advertisements extolled the virtues of "Mrs. Joe Parson's Remedy," proclaiming that "an ulcerated sore of the leg of twenty-two years' standing" had been cured by this remedy. And it took only "two dozen bottles."³

Another such advertisement was for "Botanic Blood Balm," which supposedly cured everything from cancers of all kinds to skin diseases, bone pain, blood poisoning, aching back, itching, suppurations, swellings, and festering, eating sores. That advertisement went on to say that to cure these afflictions you had first to get the poison out of your system by taking B.B.B.—a pure vegetable extract. If you had a pimple or shooting pain, B.B.B. would certainly keep it from developing into cancer. "Many hopeless cases of cancer cured by taking B.B.B. It costs only \$1.00 for a large bottle. Take enough, and it will surely work. Write for a free sample. Also describe your trouble, and special free medical advice to suit your case will be sent in a sealed letter."3

One wonders how much of this tonic was used. Appearing on the page opposite the advertisement was another for four quarts of pure seven-year-old dye whiskey, at a cost of \$3.20, express prepaid, from one of the best distillers in the nation! Elsewhere it was noted that an inferior brand of whiskey could be bought for as little as \$2.00 for four quarts. One wonders why a person would pay \$1.00 for a bottle of B.B.B. when

for just a little more he could obtain a much larger quantity of a solution of known potency.

Charles M. Strong, in his *History of Meck-lenburg County Medicine*, (1929)⁴ noted:

In its earlier days, the Society held meetings monthly, and the programs were supplied by the membership in alphabetical order, three members on each program and a fine for not appearing. Several of the earlier meetings were devoted to the establishment of a 'fee bill,' and it was finally decided that a two-fee schedule should be adopted.⁴

There was to be one set of fees for the Charlotte township and incorporated towns in Mecklenburg County, and another for "regular county practice."

State Society Meets in Charlotte

In October of 1906, with the Medical Society barely three years old, one of the most important events in its short history took place. Charlotte was chosen as the site for the fifty-third annual meeting of the North Carolina State Medical Society. In recording the three-day event, the *Charlotte Observer* stated: "There was a professional esprit de corps manifest on every hand to an extent never before surpassed in the history of North Carolina medicine." 5

Dr. Edward C. Register was at this time the president of the State Society. One item receiving special mention in the minutes of the meeting was the very elaborate and stylish dinner held on the last day. According to the minutes, ". . . words in cold type can but feebly portray the dazzling beauty of the brilliantly lighted and spacious hall with its exquisitely arranged tables, around which were gathered in the most charming and agreeable vein the 'Four Hundred of North Carolina Medicine.'"

The automobile

About this same time it was noted that many editorials in the Journal of the American Medical Association and other medical publications referred to automobiles and their use by doctors. The articles in the JAMA declared that 66 doctors from all over the United States had been polled, and that these men had written articles relating to the use of the automobile by physicians. Most of the doctors favored the practice,

but a few preferred the old horse-drawn carriage. After all the factors had been weighed, five recommendations were presented to the doctors of this time in regard to the purchase and utilization of the automobile:

- 1. Good automobiles should be made to sell for less than \$500.
- 2. Good automobiles should be durable and serve at least five years.
- 3. Automobiles should have compact engines and be able to climb any hill which a horse and buggy could negotiate.
- 4. Speed was immaterial. It was felt that there should be a law forbidding the manufacture of an automobile which would exceed a speed of more than 20 miles per hour.
- 5. The automobile should be simply constructed so that the physician himself could care for it. This would mean pleasure, as well as the saving of money, time, and temper.

Trouble over Hookworm

During the years 1908 and 1909 it was noted in the minutes of the meetings of the Mecklenburg County Medical Society, as well as in the newspapers, that a serious, severe hookworm infection was plaguing the Mecklenburg County area, and the Medical Society played a large part in combatting the disease. Dr. Annie Alexander, the first woman to practice medicine in the southeastern part of the United States, was president of the county society at this time. In the minutes of the meeting of January 19, it was noted that there was substantial evidence of forging prescriptions for whiskey, and it was moved that the secretary obtain and read at the first meeting of the Society each month the number of prescriptions each physician had written since the previous month. On February 20 Dr. Wyler moved that his prescriptions not be read aloud at the meetings, and one other doctor made a similar request. Despite its previous action, the Society passed Dr. Wyler's motion.

At the meeting on September 7 a controversy flared over the hookworm issue. Some members of the Society wanted the group to issue a statement condemning the

Evening Chronicle for printing an article criticizing the physician and his role in combatting this disease. A heated discussion followed, as members were certain that this article would harm the South and its future growth, both medically and economically. No decision could be reached at this time, and the motion was finally tabled and sent to a committee.

On December 7 the Society asked the Board of Aldermen to pass a law requiring tuberculosis cases to be reported and fixing a fine of \$50 for violations.

The County Medical Library

The Medical Library of Mecklenburg County, still one of the finest in the state, was started in 1909 "as an exchange of journals between Drs. T. H. Wright, W. D. Witherbee, R. H. Lafferty, C. N. Peeler, and William Allen." These doctors "saw the advantages of grouping the periodicals to which each subscribed, so that a larger volume of medical literature would be available to all." Two years later, in 1911, the Library Club was formed, having about 25 duespaying members. The number of periodicals and subscriptions was increased, and the binding of volumes was begun. In 1915, when the North Carolina Medical College closed its doors, "Many of the books and bound volumes were transferred to the Library Club."7

This increase in available literature and the increase in regular subscriptions (60 periodicals) led to the formation of the Charlotte Medical Library Association. By the mid-1920s the library was subscribing to 67 current journals. The total number of volumes catalogued was 1,800, including several hundred textbooks and monographs, with the remainder being bound volumes of journals. At this time various supplemental publications were being obtained from the Surgeon General's library.

Dr. Hamilton McKay, a noted urologist and former president of the Mecklenburg County Medical Society, who has been practicing medicine in Charlotte since the 1920s, was asked about the functions and contributions of the Society. He replied that, in his opinion, the most notable contribution to medicine in this area was the founding

of the County Medical Library by Dr. William Allen and others.8

Dr. Allen, it is interesting to note, conducted research on human heredity, and was awarded a grant from the Carnegie Corporation. Research then took the form of two statewide surveys of certain hereditary diseases that "wreck childhood," and as a direct result of these surveys, a course of lectures on human heredity and genetics was introduced by the Carnegie Corporation into the three medical schools in North Carolina. Dr. Allen was president of the Mecklenburg County Medical Society and of the North Carolina State Medical Society. and was an active member of the American Medical Association, the Association of American Physicians, the Eugenics Research Association, and the National Board of Medical Examiners. It is easily understood why he would appreciate the value of a library which would enable physicians to share the knowledge acquired by others in the profession.

Changing Times

In 1912 the Society changed its place of meeting to the Physicians' Club in Charlotte. At this time it was noted that the programs "had become so animated and prolonged that it was necessary to limit the presentation of a subject to ten minutes' time, and discussions to three minutes."

In 1913 there was a notation that interest in chemotherapy had been revived and that the campaign against hookworm was being carried on with great intensity. "Legal medicine and medical ethics were given formal space in the programs, and members of the faculty of the University of North Carolina Medical Department presented scientific papers on these subjects."

Little is recorded about the Society during the years 1914-1918. In 1917, however, mention was made of "several organized groups of quacks and irregular cults, such as the 'German-American Doctors' and the 'Radio Doctors' who were investigated by committees of the Society and encouraged to move to other fields of activity. In this same year the Society helped to map out the Health Department for Charlotte and was successful

in getting it started." Reference was made to the incomplete membership of the Society and to the number of doctors who were serving in the Medical Reserve Corps.

In 1923 the new Professional Building at the corner of Seventh and Tryon Streets was completed. This three-story structure was one of the finest buildings in Charlotte at the time. The company owning the building included a special meeting hall for the Society, located on the upper floor. The Society moved into its new quarters and set up the medical library in the same space, under the auspices of the Charlotte Medical Library Association.

In 1925 it became necessary for the owners to extend the structure another five stories, making it one of the largest in Charlotte. The Medical Society was moved to the eighth floor.

A Foretaste of Things to Come

In 1923 the Society was confronted by a number of issues not unlike those faced by physicians in recent times. On January 16 a resolution was introduced "that the members of the Mecklenburg County Medical Society refrain from making examinations for the benefit of Life Insurance Companies without fee." The vote was a tie and the motion was deferred to a later date. On March 6 the resolution was reintroduced and passed "That in view of the fact that it costs surgeons, physicians and hospital managers to make reports to Life Insurance Companies for operations and treatments upon patients, it is the sense of this Society that we make a definite charge for the services rendered to Life Insurance Companies and others, the amount of the charge being in proportion to the services rendered."

This controversy rages strong today, since physicians are continually receiving insurance forms which must be answered immediately, and for which they receive no pay.

In March of the same year, the head of the National Board of Chiropractors was invited to speak to the Charlotte Chamber of Commerce at its regular monthly meeting. The Society banded together to protest the honor shown to this chiropractor, and in the minutes of April 3 it is duly recorded that "The invitation to the chiropractor, Palmer, has been withdrawn."

One has only to read the newspapers to see that this feeling of ill will between medical doctors and doctors of chiropractic still exists, and editorial pages teem with protests by doctors against the type of advertising employed by chiropractors in which they may claim to cure measles and the like.

In May of this year Dr. P. M. King reported the use of insulin in the treatment of two cases of diabetic coma. From the available records, it would seem that this is the first use of insulin in the treatment of diabetes in the Mecklenburg County area.

In 1923 and 1924 "considerable effort on the part of the Society was directed toward establishing a four-year medical school in Charlotte which would be connected with the Duke University, which was undergoing reorganization under the recently created Duke Foundation." In the minutes for February 20 it was stated that "Mr. Clarence O. Kuester was introduced by Dr. I. W. Faison, and the courtesy of the floor was extended to him. He spoke of the effort being made by the Chamber of Commerce to locate a medical school in Charlotte." In May of that year open discussion of the proposal was again noted in the minutes. A committee was appointed to examine and report on the pros and cons of the question, and a prize was to be awarded to the authors of the best articles on this subject.

This, too, is a controversy that is very much alive today. On the one hand are those who urge the establishment of a medical center in Charlotte, and on the other are those who oppose the move on the grounds that it would be better to spend the money on the state-supported medical school at Chapel Hill and to invest in student aid programs at the private medical schools of Wake Forest and Duke.

In the late summer and early fall of 1923 a considerable amount of malaria and typhoid fever was reported in and around Mecklenburg County. The Society minutes record that it was "suggested that all cases diagnosed as malaria or typhoid fever have a blood examination (smear or culture) by

the Health Officer or pathologist before the case was reported." A motion to this effect was passed at the November 6 meeting.

In 1924 a medical missionary from the Belgian Congo, Dr. Kellersberger, spoke to the Society on tropical diseases. Then, as now, there was an obvious shortage of workers in this field, and Dr. Kellersberger appealed to his fellow physicians to join him in this battle in the foreign field. There is no evidence that any of the members responded to the appeal.

In August 1924 a resolution relative to a proposed tuberculosis hospital in the Charlotte area was passed by the Society. The statement read: "The Mecklenburg County Medical Society heartily endorses the establishment of a sanitorium for the care and treatment of its tuberculous citizens." (Such a hospital was subsequently established in Huntersville, between Charlotte and Davidson in Mecklenburg County.) After this meeting, as on other occasions during the summer and early fall, the meeting was adjourned and the members met in the basement to eat watermelon.

According to the minutes of the meeting in February, 1925, Dr. William Allen reported that State Senator Hamilton C. Jones wanted to know the Society's attitude toward the law forbidding a white nurse to care for a colored patient. The Society favored repeal of the law, thus reflecting an interesting attitude in view of the current racial conflict now gripping our country. It proves that as long as 40 years ago there some Southerners who were willing to compromise on the issue of segregation.

Unlicensed "Healers"

In May of the same year an Indian "medicine man" appeared in the Charlotte area and began examining patients and prescribing medicine for the treatment of various disorders. This man was without a medical license, and the Society approved a motion to have his activities investigated by the Health officer. It was understood that another "medicine man" who had begun operations in the era of Pineville, just south of Charlotte, should also be investigated. In June it was reported to the Society that the

man who had been working in the Pineville area had been indicted and was soon to be tried, but the one in Charlotte had apparently gotten wind of the investigation and had fled to New York.

In January, 1926, a Dr. Miller, in a paper read before the Society reported his experimental and clinical investigation of ephedrine. He was enthusiastic about its use in congested nasal conditions and in the treatment of asthma.

On June 18, 1926, a special meeting of the Society was called by a Dr. Northington—an unusual occurrence, since the Society normally suspended its meetings during the summer. The purpose of the meeting in this instance was to consider the presence in Charlotte of a "Dr." Julie La Salle Stevenson, a woman whom Dr. Northington considered a fraud. This woman claimed to effect cures by mystical, spiritual powers in no way related to scientific medical theory. Her purpose in visiting Charlotte was to raise money for the construction of a rest home.

Dr. Northington considered that the woman was a fraud on two counts: One, she claimed to be the sister of the chief surgeon in the American Hospital in Paris. Dr. Northington had cabled the hospital and received a negative reply from the chief surgeon there. Second, she claimed that Dr. Arthur Brishone, then editor of the Southern Medical Journal, had said of her: "God was kind when he gave the world this radiant woman." When questioned, Dr. Brishone at once not only denied ever having made such a statement but denied having any knowledge of the woman.

Dr. Stevenson, however, had so won the editor of the *Observer* to her cause that he had written several favorable editorials praising her fine work as a spiritualist and believer in healing by nonmedical means. She evidently possessed an attractive appearance and a charming personality to aid her cause.

Dr. R. F. Leinbach, who was president of the Mecklenburg in 1926, was recently questioned about his recollections of the affair. He replied that he remembered the controversy quite well. He had interviewed this woman, much against his wishes, when an interested party thrust her into his office and demanded that he speak with her. Their conversation was quite interesting, he said, and his feelings differed from those of Dr. Northington.

Contrary to Dr. Northington, Dr. Leinbach did not believe that the woman was really trying to defraud anyone. He felt, rather, that her motives are creditable but that she was largely ignorant. She knew no medicine nor anatomy. What she did possess was a firm belief that people could be healed through faith and good works and the use of mystical powers. She was sincerely interested in trying to establish, in the area of Lake Lure, a sanitorium that would be a haven for the afflicted who felt as she did that cures could be effected through faith and not solely by medicine. Dr. Leinbach further considered her to be "ignorant of medical practices and medical ethics, but meaning only to do good and not acting with ill intent."10

The Mecklenburg County Medical Society, for its part, passed a protest designed "to protect the people and the health of Mecklenburg County and the rest of the state" from such people as this woman. It cautioned the editors of the *Observer* to be more careful in what they printed about medicine and related subjects because of the paper's widespread influence in the area.

In December, 1926, Dr. Alonzo Myers was reprimanded for writing an editorial for the *Virginia Medical Monthly*, and Dr. A. Wylie Moore for contributing an article to the *Observer* "Subluxation of the Sacroiliac Joint." Both of these men submitted written apologies to the Society for having published articles.

On being questioned about this action, Dr. Leinbach stated that in 1926 it was considered improper and unethical for a physician to advertise himself by the publication of articles (or any similar means) which brought his work to the attention of the public and created a "glorious attitude toward his work or made him appear superior to other doctors. Later, Dr. Leinbach said, others began to recognize this means of attain-

ing free publicity, and the quantity of medical articles seemed to increase from this time forth.¹⁰ The practice is certainly well established today, it being quite common for articles to appear in newspaper and popular print on such medical subjects as new methods of treatment, unusual achievements, and dramatic discoveries.

A Flourishing Society

The records of the Medical Society of Mecklenburg County contain a number of errors and discrepancies. (In one place it is stated that "Dr. Annie Alexander reported a case of insanity following insanity.") Nevertheless the minutes are by far the most complete record of the Society's growth during the first quarter of the twentieth century.

The Society that began with only 42 charter members by 1925 had grown to include a membership of 125 strong. Through the work of its members the medical library was founded and continued to flourish. Yet it is well known that medicine would have advanced and the number of doctors increased without any organization. The purpose of the Society seems to have been to provide unity of purpose and strength of drive toward the goal of better medical practice. It seems that in 1925 the organization, as Dr. E. C. Register had prophesied in 1903, was well on its way to becoming "the most flourishing society in North Carolina."

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323 Lockland Avenue

Winston-Salem, N. C.

Report on Trauma

TETANUS PROPHYLAXIS

The following is a resume of the principles of tetanus prophylaxis as published by the American College of Surgeon's Committee on Trauma, the Subcommittee on Prophylaxis against Tetanus. It should be pointed out that all outhorities do not agree with the details of tetanus prophylaxis, but there is unanimity of opinion concerning the principles involved.

A. General Considerations

- Thorough cleansing and adequate debridement of wounds, at times with the wound being left open, are the most important aspects of the prophylaxis against tetanus.
- 2. Antitoxin is not necessary in clean, superficial wounds.
- 3. When really necessary, the doses of antitoxin should be at least 5,000 units.
- 4. Individuals with basic immunization with toxoid in the past may have an adequate level of protection recalled by a booster no matter how many years have elapsed since the course of basic immunization (see below).
- 5. Penicillin and broad spectrum antibiotics in full doses are quite effective against the vegetative form of *Clostridium tetani* which produces the toxin. They must be started promptly and continued for a minimum of ten days. However, antibiotics should not be used as a substitute for tetanus prophylaxis.

B. Basic Immunization

- 1. Primary active immunity is obtained by giving three doses of alum-precipitated toxoid, subcutaneously. The second dose is given one month after the first; the third, six to twelve months later. Periodic booster doses are then given at intervals of four years.
- 2. Infants and children up to four years

of age receive tetanus toxoid in combination with diphtheria toxoid and pertussis vaccine, given at monthly intervals for three doses with a fourth dose one year later.

- C. Management of Patients Previously Immunized with Toxoid
 - 1. Patients who have received their basic immunization or a booster dose within four years are given 0.5 ml. of alum-precipitated or fluid toxoid subcutaneously.
 - 2. Patients who have received their basic immunization but have not had a booster dose within four years of the time of injury are generally adequately protected with a booster of toxoid alone. If the wound, however, has a strong possibility of tetanus infection, additional protection can be given for the first few days by the administration of 5,000 units of tetanus antitoxin given in one arm, while with a separate syringe and needle 0.5 ml. of alum-precipitated toxoid is given in the other arm. The tetanus antitoxin is given only if the patient is not sensitive to horse serum. (See below)
- D. Management of Patients not Previously Immunized with Toxoid
 - 1. Patients with clean superficial wounds in whom passive immunization (antitoxin) is not indicated and who have *not* been previously immunized with toxoid, should have the basic immunization begun immediately.
 - 2. Patients without previous immunization whose wound indicates the need for tetanus prophylaxis, should be given 5,000 units of tetanus antitoxin. Using another syringe and needle and in a different extremity, the basic active immunization is begun by giving 0.5 ml. of alum-precipitated toxoid, and arrangements are made to in-

Fifth in a series of articles by the Committee on Trauma, North Carolina Chapter, American College of Surgeons.

- sure completion of the basic active immunization.
- 3. In patients who are sensitive to horse serum (see below), but who are found not to be sensitive to bovine serum, give 5,000 units of bovine antitoxin.
- 4. If the patient has a mildly positive or a suspected history of sensitivity or mildly positive or suspected sensitivity test, administer 0.1 cc. of a 1:10 dilution of antitoxin subcutaneously, having adrenaline in a syringe ready to use. If no reaction occurs in 30 minutes, 0.1 ml. of undiluted antitoxin is given subcutaneously or intramuscularly.
- 5. If reaction occurs to the above tolerance test, or if there is a clear-cut history of severe reaction to both horse or bovine serums, do not give antitoxin. Human hyperimune globulin may be given if available, or a transfusion from a donor who has received a booster dose of toxoid one month previously. The wound must be adequately debrided and left open. Penicillin or tetracycline must be given promptly, or in full doses, for a minimum of ten days. As noted above, basic active immunization with alumprecipitated tetanus toxoid, should be begun simultaneously.
- E. Determination of Sensitivity to Horse or Bovine Serum
 - 1. Prior to the administration of any animal serum, all patients must be carefully examined for possible sensitivity to that serum. The patient must be carefully questioned concerning allergic reactions, such as asthma, eczema or urticaria or reactions to previous injections of horse or bovine serums.
 - 2. Skin tests. 0.2 ml. to 0.3 ml. of a 1:10 dilution of tetanus antitoxin in saline is injected intracutaneously. A hivelike wheal with erythema appearing within fifteen minutes and measuring approximately 1 centimeter in diameter indicates a sensitivity to horse serum.

3. Eye tests. Place a drop of a 1:10 dilution of tetanus antitoxin in the conjunctival sac of one eye at the time the skin test is made. Redness of the conjunctiva occurring in five to ten minutes indicates a positive reaction. If the test with 1:10 dilution is negative and the skin test is positive, the eye test should be repeated with the concentrated tetanus antitoxin. After the result is apparent, a drop or two of adrenaline 1:1000 should be instilled in the test eye.

Recent evidence, as published by the Council on Drugs in the Journal of the American Medical Association, May 10, 1965, suggests that part of the above discussion concerning the sensitivity of patients to horse or bovine serum has been altered in significance by the introduction of human tetanus immune globulin (Hyper-Tet). As was stated in that article, this is a result of an initial assessment of this new drug on the basis of available evidence and does not "necessarily represent the final opinion of the Council on Drugs, nor does it imply approval, endorsement, or acceptance of the drug."2 Because of the importance of this drug, the following is quoted from their article. The reader is referred to the reference cited below for their complete statement.

Tetanus immune globulin is effective prophylactically in patients with wounds that may be contaminated with Clostridium tetani, and is virtually free from the risk of inducing hypersensitivity. It is particularly useful when a history of active immunization with tetanus toxoid cannot be established with reasonable certainty, and when the risk of immediate or delayed reactions to equine antitoxin must be avoided (patients known to be sensitive to horse serum, or those who have a history of allergy). When a history of previous active immunization within 15 years can be established, the administration of a reinforcing (booster) dose of tetanus toxoid is preferable.

Passive immunization with tetanus immune globulin at the time of injury should not be regarded as a substitute for active immunization with tetanus toxoid prior to injury, nor as a substitute for adequate medical and surgical care of contaminated or potentially contaminated wounds.

All authorities agree that active immunization with tetanus toxoid should be instituted in those patients who receive passive immunization with tetanus immune globulin. However, some feel that the initiation of such a program should be delayed for one month after the administration of tetanus immune globulin, whereas other authorities believe that interference with antibody response from the passively acquired material is not sufficiently great to outweigh the advantage of beginning active immunization when the patient is at hand.

Passively acquired tetanus toxin antibodies from human gamma-globulin persist for an extended period; their half-life is thought to be at least three weeks and possibly more than four weeks. By contrast, tetanus toxin antibodies from heterologous sources (eg, equine or bovine antitoxins) have a relatively brief half-life, which may be as short as two or three days but is subject to considerable variation.

Studies on the absorption and persistence of tetanus immune globulin indicate that about one half of an intramuscular dose appears in the plasma. The injection of 4 to 5 units per kg of body weight ensures a plasma level above 0.02 units per ml for as long as four weeks; it is considered that this level is adequate to protect against all but a fulminating tetanus infection.

Adverse Reactions and Precautions

Like all other gamma-globulin preparations, tetanus immune globulin should be given only intramuscularly; it should never be given intravenously. The possibility that allergic reactions may occur is very remote. Unless extraneous contamination occurs, there is virtually no likelihood of transmitting viral hepatitis by the administration of this agent.

Dosage and Preparations

Route of Administration.—Intramuscular

Dosage.—For passive immunization, the usual dosage for adults and children is 4 units per kg of body weight (250 units may be given to an adult), although larger doses may be used.

For the treatment of tetanus, the administration of 3,000 to 6,000 units has produced satisfactory results. Higher doses have also been used; the optimal therapeutic dosage has not been established.²

In summary, the best protection against the development of clinical tetanus is adequate debridement and very thorough cleansing of the wound, and prior active immunization with tetanus toxoid. In all patients seen, regardless of the reason, the physician has a moral responsibility to see that the patient is actively immunized against tetanus. The availability of human tetanus immune globulin promises to considerably lessen the hazard of hypersensitivity; however, the reader should carefully watch the medical literature for further reports concerning the use of this new drug.

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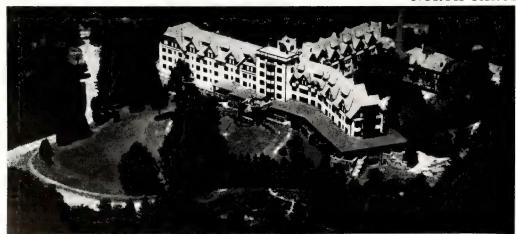
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May, 1966

MEETING IN THE "LAND OF THE SKY"

The One Hundred Twelfth Annual Meeting of the Medical Society, at Asheville, though plagued by the low attendance characterizing recent annual meetings despite increasing society membership, displayed the attributes of a well planned, expertly conducted, and productive convention. Hosting and social functions were of rare elegance, exhibits and scientific program were of sufficient variety and breadth to satisfy the most discriminating member, and the business of the meeting, both Executive

Council and House of Delegate Sessions, was carried out with dispatch in the allotted time scheduled.

The only significant alteration in format was the elimination of the customary Sunday night Memorial Service and its inclusion at the beginning of the first meeting of the House of Delegates on Sunday afternoon, honoring, with simple dignity, the memory of 59 members of the Society deceased during the past year.

The work of the House of Delegates was measurably facilitated by the action of two reference committees, which, after holding open hearings on 19 submitted resolutions, were able, by blending similar proposals, to report six propositions to the House of Delegates for action at its second meeting. These final drafts were adopted with no serious objection and with only minor word changes.

The most significant action involved a reconsideration of the position established prior to the implementation of the Kerr-Mills Law, when, at a called meeting in February, 1961, the House of Delegates chose to forego vendor payments for physician's services to Kerr-Mills recipients "at this time." Doctors of medicine have traditionally, throughout history, freely rendered service where needed without regard to ability to pay. Public Law 89-97 provides for payment of customary and reasonable fees for such service to recipients of benefits under the law. In keeping with the action of the AMA House of Delegates, action was taken in Asheville to broaden this concept to include all government-sponsored programs and, ultimately, all programs already in effect established with fee schedules at lower than usual and customary fees. The House of Delegates further authorized the Executive Council to "suspend. discontinue or modify" existing agreements relating to professional fees with government agencies and other parties.

Creation of a "Medical Foundation" was approved and the Finance Committee was authorized to transfer to the Foundation sufficient assets to permit the purchase of a site in Raleigh for the proposed construction of a Headquarters facility.

This last Annual Meeting B.P. (Before Pinehurst) closed a year marked by strong landership and launched the Society on a new period assured of competent and objective direction at the hands of its new President.

J.S.R.

Registration—Annual Meeting

Members—534 Auxiliary—177 Medical students—114 Guests—112 Scientific exhibitors—68 Technical exhibitors—207

DEFECTIVE JOURNAL COPIES

Mr. Lyn Ragan, proprietor of the press which prints the Journal, has recently admitted that his establishment is staffed by human beings as well as machines. Both elements of the plant occasionally go astray, and faulty copy of the Journal may reach a reader. If so, just let Mr. Ragan know—the address of the press is on the first editorial page of each issue—and he will send another copy to you. Persistent complaint of this nature might well be directed to the attention of the Business Manager, Mr. James T. Barnes.

MEDICAL SCHOOL DROPOUTS

Much attention has been paid in the past few years to the increased rate at which medical students leave school without getting a degree. Some leave for academic reasons, others because of physical and psychiatric problems, still others for reasons that are not too clear to themselves or to the school. Expressing the increased rate as numbers of people, we are losing the equivalent of the entering classes of 10 average-sized medical schools each year (about 900 students per year).

Academic preparation seems to have been better recently, and objective measures of ability and achievement indicate that today's premedical students are better equipped than we were to make the grade. The unresolved question is whether the increased failure rate stems from something being done in medical school, or something that is happening in society at large. Since the increased dropout rate has affected all the medical schools, it does not seem to result from faults in certain faculties or curriculums. While the content of medical school courses would make it difficult for most practicing physicians to last beyond the first few weeks, especially in biochemistry, the students are prepared to handle the material.

Turning to the non-academic possibilities. could it be that students today are not running scared? President Johnson and his advisors have been accused by some economists of basing the administration's economic programs on the catastrophes of the Great Depression, of overreacting to alarms that are no longer valid. It is certainly true that medical students of the 1930's and 1940's had seen enough of the Depression to run scared, and to think that dropping out of school was a step on the road to ruin. We must remember that this reaction is not necessarily built into the present generation. They have never known want, except in the abstract. Most medical students come from the middle economic groups and have experienced want only in terms of the most frivolous sort, like getting thirsty while sitting in church. Withal, they have been counselled from early days to "find themselves," to seek a blend of their abilities and opportunities that will make them happy people. Therefore, when they get to medical school their objective is to finish, but only if to finish would mean fulfillment. If they find the way unpleasant, it is interpreted as a sign that they chose the wrong career and will have to find happiness elsewhere. And elsewhere is available, not out of reach as it often was in less prosperous times.

It may just be that the medical schools are going to have to resign themselves to a chronically increased dropout rate, at least so long as prosperity is with us. And who would wish to trade a reduced dropout rate for another depression?

One of the objectives of the North Carolina Heart Association is to inform the community of measures that might be taken to reduce the risk of heart attack.

Correspondence

To the Editor:

The brief statement prepared by Lieut. Colonel Alfred G. Siege seems unusually pertinent at this time. We are seeing similar reports from other states much more frequently indicating the immense value of Dr. Bickley's article which you published in the July, 1965, NORTH CAROLINA MEDICAL JOURNAL.

I should mention that the first human case of rabies (from a skunk bite) in Minnesota since 1917 was reported in the JAMA, October 25, 1965.

W. L. Wilson, M.D., Director State Radiation and Occupational Health Protection Program

RABIES FROM A MONGOOSE BITE

Lieut. Col. Alfred G. Siege, U. S. Army Medical Corps Chief, Preventive Medicine Division Fort Bragg

The danger of rabies is ubiquitous. The recent NORTH CAROLINA MEDICAL JOURNAL article on rabies¹ prompts this brief report.

Not long ago, while sitting on his bunk, a young Airman on duty in the Dominican Republic, was bitten by a mongoose. The mongoose, common in this area, had crawled under a tent flap and bit the airman on the big toe as he sat, removing his boots and socks. The animal then ran about the tent and leaped at a pair of fatigue trousers, into which he fastened his teeth.

The animal was killed by a blow to the head, refrigerated, and sent to Fort Bragg promptly at the same time as the patient. Brain tissue of the mongoose, subjected to examination by fluorescent antibody technique, revealed numerous rabies virus bodies.

The patient was treated with hyperimmune serum and a 21-day series of injections of duck embryo antirabies vaccine. He has had also his two booster inoculations, spaced on the tenth and the twentieth days following the last day of the initial series.

The danger of rabies from wild as well

as domestic animal bites, and the necessity for laboratory diagnosis, where indicated, followed by complete and very prompt prophylactic treatment cannot be overemphasized. Fortunately our recent medical literature confirms the increasing importance of combatting this threat.

Reference

 Bickley, S. T.: Rabies-Recent Advances in Diagnosis and Prophylaxis, N C Med J 26: 265-280 (July) 1965.

NORTH CAROLINA ASSOCIATION OF PROFESSIONS

To the Editor:

The attached statement by President William W. Dodge, III, A.I.A. is to go into the next issue of the journal for each of the respective member organizations. We will appreciate your cooperation in encouraging membership in the North Carolina Association of Professions.

Annette S. Boutwell Executive Secretary

February 16, 1963, was the date the North Carolina Association of Professions met to elect its first officers.

Since that day many things have happened. Each was a step forward. Today we are still moving forward. We are now in our fourth year and our raison d'etre remains the same: "to better utilize our professional knowledge and skill for the benefit of society and to create relationships between the several professions looking toward that end."

Membership is still open on an individual basis. The way is open for you to participate in activities that are directed to the benefit of us all. One supports the other four. The four support the one.

You have a responsibility as a professional to take advantage of this opportunity to join hands with other professionals in North Carolina to strengthen the integrity of their training and practice.

Annual membership is five dollars per year payable to:

North Carolina Association of Professions P. O. Box 10387

Raleigh, North Carolina

Bulletin Board

COMING MEETINGS

Workshop on Community Mental Health Center Planning—Pisgah View Ranch, Candler, June 8-14.

American College of Physicians, Postgraduate Course on Neurology for the Internist—Hotel Robert E. Lee, Winston-Salem, June 16-17.

Tri-State Medical Association, Annual Meeting—Carolinian Hotel, Nags Head, June 17-19.

New Hanover County Medical Symposium—Blockade Runner Hotel, Wrightsville Beach, August 12-13.

North Carolina Association for Retarded Children— Jacksonville, September 16-17.

Charlotte Postgraduate Seminar—Presbyterian Hospital, Charlotte, September 21-22.

Forsyth County Heart Symposium—Winston-Salem, September 30.

North Carolina Pediatric Society, Annual Meeting—Mid Pines Club and Golfotel, Southern Pines, November 4-5.

NEW MEMBERS OF THE STATE SOCIETY

Drs. Charles Dixon Wallace, Sr., P. Reade Road, Chapel Hill; Vincent Taormina, N. C. Memorial Hospital, Chapel Hill; Irvin Samuel Perry, I, N. C. Memorial Hospital, Chapel Hill; Joseph Stephen Pagano, I, N. C. Memorial Hospital, Chapel Hill; Moses Stephen Mahaley, Jr., 3534 Hampstead Court, Durham; Dr. Myron Bennett Liptzin, P, 320 Woodhaven Road, Chapel Hill; Richard C. Lester, R, 1511 Pinecrest Ave., Durham; Norris Alexander Jones, Jr., R, 2119 Pershing St., Durham; James Pitzer Gills, Jr., Oph, 2528 Wrightwood Ave., Durham; Norbert Beverly Enzer, P, 2017 Darmouth Drive, Durham.

Also, Drs. Arthur Chris Christakos. ObG, 2904 Winton Road, Durham; Michael Paul Capp, R, 806 Starmont Drive, Durham; James Alexander Bryan, II, North Carolina Memorial Hospital, Chapel Hill; William Paul Clezen, Pd, 309 Clayton Road, Chapel Hill; George Dewey Wilbanks, Jr., ObG, 3615 Dover Road, Durham; Robert Amasa Chapman, S, Cannon Memorial Hospital, Banner Elk; John Robert Spengler, R., Pardee Memorial Hospital, Hendersonville; Walter Graham Bullington, Oph, 1012 Kings Drive, Charlotte; James Gordon Todd, Jr., I, 202 S. Caldwell St., Brevard; Sion Leo Record, Jr., East Manor Ridge Road, Elkin.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Dr. Sanford I. Cohen, professor of psychiatry at Duke University Medical Center, has been awarded a Commonwealth Fund Fellowship for brief studies in Czechoslovakia and the Soviet Union this summer.

Dr. Cohen's chief research interest is the psychophysiologic aspects of cardiovascular disease. The fellowship will enable him to do detailed, critical evaluation of the technique and methods used in this work in laboratories in these countries.

While in Russia, Dr. Cohen will attend the International Congress of Psychology in Moscow in August and present a review of the work being done at Duke on cardiovascular conditioning.

* * *

Seventeen white mice have provided science with the clue that ultimately may enable man to live and work under water, a Duke University researcher reports.

While studying the process of drowning, the researcher found it was possible for the mice and other animals to breathe water, just like fish.

The discovery was made by Dr. Johannes A. Kylstra, assistant professor of medicine and physiology, who began his experiments in Holland several years ago. He continued them at State University, Buffalo, N. Y. before joining the Duke faculty.

The work has led him to believe that man might be able to live and work on the sea bed by breathing water in the same manner as fish.

His research was discussed in a paper he presented at the third International Symposium on Underwater Physiology in Washington March 23-25.

In his experiment Dr. Kylstra proved that the lungs of the research animals could act as reasonably efficient gills, provided the inhaled water is previously enriched with oxygen. He and his colleagues did this by keeping the mice under water for as long as 18 hours and the other animals for up to 45 minutes.

Dr. Kylstra's research is continuing at Duke Medical Center. Considerable work will still have to be done before a man is submitted to an experience similar to the one the mice underwent.

Dr. Kylstra was one of five Duke scientists participating in the symposium. The others were Dr. H. A. Saltzman, assistant professor of medicine; Dr. John Salzano, assistant professor of physiology; Dr. Willis H. Bell, a fellow in medicine, and Dr. William B. Weglicki, a fellow in cardiology.

Long the butt of many a sad joke, gout victims soon will be offered new hope for relief of their painful and sometimes fatal disease.

A drug called allopurinol, first used successfully on patients at Duke University, has been tested widely and is expected to be released soon by the Federal Food and Drug Administration.

Largely on the basis of the Duke research and on other studies, the drug was released in March for general presciption use in Great Britain.

Allopurinol has been found to be the most useful chemical agent yet developed in the control of gout, said Dr. R. Wayne Rundles, who conducted the Duke research project over the past three-and-a-half years. Studies done elsewhere confirm the findings.

Medicare, the federally supported health insurance plan, eventually will offer coverage for the disabled and the unemployed, a Duke University professor predicted in an interview recently. There is every reason

* * *

to believe they, as well as the aged, will be classified as beneficiaries, he insisted.

The statement was made by Ray E. Brown, a nationally recognized authority on Medicare, hospital costs and insurance. He is professor of hospital administration and director of the Graduate Program in Hospital Administration at Duke.

Coverage for the disabled and unemployed will be required because of the burden they impose on the financing of our hospital system, and because their dignity and their need to be treated like everyone else demands it, Brown said.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Harold R. Roberts, 36-year old assistant professor of pathology and medicine at the University of North Carolina School of Medicine, has been selected a recipient of a 1966 Lederle Medical Faculty Award.

Lederle awards, valued at up to \$10,000 for each of three years, are to promote the abilities of young physicians in the U. S. and Canada as medical investigators, teachers and scholars.

Dr. Roberts also is associate director of the Clinical Coagulation Laboratory, a diagnostic and treatment center for patients with hereditary bleeding disorders, such as hemophilia.

He is a native of Four Oaks in Johnston County and received his medical degree from UNC in 1955. Between his internship and residency training at Vanderbilt University Hospital in Nashville, Tenn., he was a Fulbright Scholar in Experimental Medicine in Denmark for a year.

He was a Neurology Fellow in 1959-60, a Hematology Fellow in 1960-61 and joined the medical faculty at UNC in mid-1961 as a research associate in pathology.

Dr. Frank C. Wilson, Jr., assistant professor of orthopedic surgery at the University of North Carolina School of Medicine, has been appointed a Markle Scholar in Academic Medicine.

He is one of 25 young medical scientists in the U. S. and Canada selected for the honor by the John and Mary Markle Foundation of New York City.

Dr. Wilson is a native of Rome, Ga., and joined the UNC medical faculty as an instructor on January 1, 1964. He came to Chapel Hill after five years at Columbia Presbyterian Medical Center in New York City.

The Markle Foundation now has selected 11 medical faculty members at UNC as Scholars. Its grants have been made annually since 1948 "to relieve the faculty shortage in medical schools by giving support to young teachers and investigators early in their careers."

Miss Euzelia C. Smart of Chapel Hill has been appointed to a three-year term on the Joint Committee of the American Hospital Association and the National Association of Social Workers.

* * *

She is director of the Social Work Department at N. C. Memorial Hospital in Chapel Hill and associate professor of social work at the University of North Carolina School of Medicine.

The Bown-Hazen Fund of Research Corp. of New York City has awarded a \$5,323 grant to the University of North Carolina in Chapel Hill to help provide research assistance in a medical electronmicroscopy laboratory.

The funds will supply technical support for a group of researchers in the Department of Pathology at the UNC School of Medicine who are working on kidney and infectious diseases.

* * *

What happens to the kidneys from the long-term use of certain drugs will be studied at the University of North Carolina School of Medicine under a \$61,000 federal research grant.

The National Institute of Arthritis and Metabolic Diseases has approved a five-year grant to Dr. Christopher C. Fordham, III, associate professor of medicine for "Studies in Relation to Drug-Induced Renal Disease."

Co-investigators are Dr. L. G. Welt, Chairman of the Department of Medicine, and Dr. W. D. Huffines of the Department of Pathology.

Parents of preschool children with hearing problems were invited to the Hearing and Speech Center at N. C. Memorial Hospital recently to consider forming a permanent parent oganization for North Carolina.

No such organization now exists in the state.

The state group plans to seek affiliation with the Parents' Section of the Alexander Graham Bell Association for the Deaf in Washington, D. C., an international parents' organization.

A highlight of the all-day session in Chapel Hill was a talk by Mr. and Mrs. Thomas Gantt of Durham in which they explained their experiences with a hard-of-hearing son, Greg, now five and completing his first year at the Eastern North Carolina School for the Deaf in Wilson.

A goal of the new organization will be to strengthen and expand facilities in the state for deaf and hard-of-hearing children.

A tiny disease-causing germ which puzzles medical researchers because it resembles both bacteria and viruses was discussed at a meeting of the Elisha Mitchell Scientific Society in Chapel Hill recently.

Dr. G. P. Manire, bacteriologist at the University of North Carolina School of Medicine, spoke on "Psittacosis Organisms—Viruses or Bacteria?

Like viruses, the germs grow only in living cells. But unlike viruses they can be killed by penicillin and other antibiotics. In their chemical makeup, they are more like bacteria than viruses.

Dr. Manire is the principal investigator for a research study of psittacosis organisms. The study has been in progress for 10 years at UNC.

Ronald B. Milch, research administrator at Montifore Hospital and Medical Center in New York City for the last two years, has been appointed executive officer for the Center for Research in Phamacology and Toxicology at the University of North Carolina School of Medicine in Chapel Hill.

He will have the title of assistant to the dean of the medical school.

Milch's appointment follows by about seven months the selection of the UNC campus as the location for a \$17 million pharmacology-toxicology research center, one of about four being considered in the U.S.

Plans for a building to house the center are now underway.

Eight research projects at the University of North Carolina School of Medicine have been selected for presentation at the 50th annual meeting of the Federation of American Societies for Experimental Biology in Atlantic City, New Jersey.

Scientific papers from UNC will be by Dr. Campbell W. McMillan and others; Dr. R. A. Weaver and others; Joe Paul Hurt and others; Dr. N. F. Rodman; Dr. Paul P. Leyssac; Dr. Henry N. Kirkman; Patricia A. Moore and others; Dr. J. E. Wilson and others.

Some of the crucial ethical decisions which face physicians who bring babies into the world were considered in the first Merrimon Lecture at the University of North Carolina recently.

The speaker was Dr. Nicholson J. Eastman, professor emeritus of obstetrics at Johns Hopkins University School of Medicine in Baltimore, Md., and consultant to the Ford Foundation in New York City.

His topic was "Induced Abortion and Contraception: A Consideration of Ethical Philosophy in Obstetrics."

The Merrimon lecture was established at the UNC School of Medicine with a \$100,000 beguest from the late Dr. Louise Merrimon Perry of Asheville in honor of her father's family.

The annual lectures will be concerned with "the origins, traditions, and history of the medical profession and the ethical philosophy which must dominate this field of human endeavor."

* * *

The library at the University of North Carolina

Health Center in Chapel Hill has joined a teletypewriter exchange network (TWX) to speed up the exchange of information and material between the five medical school libraries in North Carolina and Virginia.

Miss Myrl Ebert, director of the Division of Health Affairs Library, said the system is expected to be used in a program of cooperative acquisition of library materials and to speed up inter-library loan transactions.

Dr. William R. Straughn, bacteriologist at the University of North Carolina School of Medicine, participated in the 16th national convention of Alpha Epsilon Delta, national premedical honor society, at Emory University in April.

He presided over a conference on "Preparation for the Practice of Medicine in the Next Decade" and was a panelist for a discussion of "Medical School Admission Requirements."

The Milbank Memorial Fund of New York City has approved a development grant of up to \$7,600 to the University of North Carolina School of Medicine to conduct a series of regional medical meetings in the economically depressed Appalachian Region.

The grant will help the Advisory Committee on Health of the Appalachian Regional Commission acquaint practicing physicians, public health officers, and medical educators with the Appalachian Regional Development

The Advisory Committee on Health, whose staff is directed by Dr. Robert R. Huntley and Dr. Carl B. Lyle of the UNC medical school, has recommended that the health needs of Appalachia can best be met with more services rather than more buildings.

The 70 students who will enter the University of North Carolina School of Medicine next fall were selected from more than 600 applications.

In his annual report to the UNC Medical Alumni Association in Chapel Hill, Dean Isaac M. Taylor said that competition for admission to the medical school increases as the babies born during the post-World War II boom reach medical school age.

He said that plans are being made to increase the number of new students entering medicine in Chapel Hill from 70 to 75 in the fall of 1967.

The UNC medical school now has 279 students, one under a full complement of 280 and probably the largest student body in its history.

Dean Taylor's report followed the election of new officers at the annual business meeting of the medical alumni.

Dr. John R. Chambliss of Rocky Mount was elevated to the presidency, succeeding Dr. John F. Lynch, Jr., of High Point.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. I. Meschan, professor and chairman of the Department of Radiology, was recently appointed chairman of the American College of Radiology's Committee on Radiobiology. He also was named to the organization's Commission on Education and to the Committee on Organization and Support of Teaching Departments.

Dr. William H. Boyce, professor of urology, was recently presented the "Service to Mankind Award" by the Winston-Salem Sertoma Club. The award, a plaque, is presented annually for outstanding humanitarian activity, heroism, or civic work.

The Department of Health, Education and Welfare has awarded the Bowman Gray School of Medicine an \$84,000 grant to support, for a three-year period, a research project in family planning and birth control.

Dr. Clark E. Vincent, professor of sociology, will direct the studies which will be conducted in poverty areas, primarily with unwed mothers. The work is intended to provide a better assessment of the problems and what can be done to solve them.

Data from the studies will be used in a comprehensive program on marital health, family life education, and human sexuality which is being developed in the medical school's recently established Behavioral Sciences Center.

Aims of the broader program are to provide medical students, interns, and resident physicians with more extensive training in the field of family life problems.

The work will include studies on marriage failures and their relationship to juvenile delinquency and illegitimacy.

Dr. John I. Dalland, research assistant professor of otolaryngology at the Bowman Gray School of Medicine, has been awarded a \$79,200 grant by the National Institutes of Health to support a three-year study of the auditory capabilities and mechanisms of bats.

The bat has such a highly-developed auditory system that it is able to catch flying insects, avoid fine obstacles in its flight path, migrate hundreds of miles, and fly in pitch darkness-all without the aid of vision.

Such impressive navigational feats are accomplished by means of a built-in sonar system which seems to provide this animal with an accurate and detailed picture of the world around it.

Dr. Dalland believes that the study of the auditory system of echo-locating bats will contribute to a better understanding of hearing mechanisms in general.

For his experiments he is using the big brown bat, actually a misnomer. The adult of the species weighs only about 20 gm, slightly more than one-half ounce.

* * *

The 1966 graduates of the Bowman Gray School of Medicine will intern at 24 hospitals in 16 states. Their internship appointments will become effective July 1.

The appointments were made through the National Intern Matching Program. Seventy-eight per cent of the class received first-choice appointments. Nineteen of the seniors will remain in Winston-Salem and will serve internships at North Carolina Baptist Hospital.

* * *

Dr. C. Max Lang, fellow in laboratory animal medicine at the Bowman Gray School of Medicine, has been appointed to the faculty of the Milton S. Hershey Medical Center, Hershey, Pa. When his appointment as assistant professor of laboratory animal medicine becomes effective July 1, he will become the seventh trainee of the department to fill an academic position.

Dr. D. LeRoy Crandell, professor of anesthesiology, spoke on "Staff Organization" at a meeting of the Southern Professors of Anesthesiology March 3-5 in Baltimore, Md.

Dr. Frank C. Greiss Jr., assistant professor of obstetrics and gynecology, presented a paper on "The Uterine Vascular Bed: Effect of Automatic Stimulation" at a meeting of the Society for Gynecologic Investigation March 24 in San Francisco, Calif.

Dr. Weston M. Kelsey, professor and chairman of the Department of Pediatrics, served as Visiting Professor of Pediatrics at Ohio State University School of Medicine March 17-20 in Columbus, Ohio. He also was guest lecturer for a symposium, "Two Days of Pediatrics," March 9-10 at the Medical College of South Carolina. His topics were "Rheumatoid Diseases in Children" and "Misuse of the Laboratory in Thyroid Disease."

Dr. William M. McKinney, assistant professor of neurology, presented two papers and conducted a workshop on "Echoencephalography" at a recent symposium on "Diagnostic Ultrasound" at the University of Colorado Medical Center. He spoke on "Echoencephalography: General Principles and Problems" and

"Ultrasonic Intracranial Pulsations."

Dr. Quentin N. Myrvik, professor and chairman of the Department of Microbiology, participated in the American Medical Association's Air Pollution Medical Research Conference in Los Angeles, Calif. He presented a paper on "Metabolic and Immunologic Activities of Alveolar Macrophages."

* * *

* * *

Mrs. Ethel M. Nash, assistant professor of preventive medicine and Dr. Clark E. Vincent, professor of sociology, participated in a symposium on "Sexual and Family Problems in Obstetrics and Gynecology," presented as part of the centennial celebration of Columbia Hospital for Women March 26 in Washington, D. C. Mrs. Nash, who is president of the American Association of Marriage Counselors, spoke on "Marriage Counseling." Dr. Vincent's topic was "Sociology of Adolescence."

Mrs. Nash also spoke on "Sex Morals on the College Campus" at Bennett College, Millbrook, N. Y.

Dr. Vincent delivered three major lectures at Colorado Women's College in Denver, Colo. He spoke on "Unmarried Mothers: Problem or Symptom?", "The Sex Factor in Human Life and Culture," and "Professional Workers and Rehabilitation with Unmarried Parents."

While in Denver, he also spoke on "The Marital Dyad" at the University of Colorado Medical Center and lectured on "Issues in the Pastor-Physician Relationship" at the University of Denver's School of Theology.

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ANNOUNCEMENT

A group of investigators at the Bowman Gray School of Medicine ask your help in locating patients with Down's syndrome who may have one of the translocation types of this disorder. A large proportion of patients who have a sibling, cousin, or paternal or maternal relations with the same disorder are translocation types.

Please notify Dr. Harold O. Goodman, Department of Preventive Medicine and Genetics, Bowman Gray School of Medicine, Winston-Salem, if you have treated or know of such families. Contact with the families will be established only through notifying physicians. Studies of chromosomes and of metabolic abnormalities will be undertaken without cost to subjects.

GREAT SMOKY MOUNTAINS PEDIATRIC SEMINAR

The Great Smoky Mountains Pediatric Seminar (formerly known as the East Tennessee Pediatric Association will have its annual meeting in Gatlinburg, Tennessee, June 9-11, 1966.

Speakers this year are:

Dr. James N. Etteldorf; Dr. Harry C. Shirkey; Dr. Charles Reiser, pediatric urologist; and Dr. John R. Maddox, Jr., pediatric surgeon.

Any physician interested in children is welcome.

For information, write Dr. John C. Rochester, Secretary-Treasurer, Great Smoky Mountains Pediatric Seminar, 4807 Newcome Avenue, N.W., Knoxville, Tennessee 37919.

NORTH CAROLINA CONFERENCE FOR SOCIAL SERVICE

Many professional people, ministers, social workers, counselors, public health nurses and others are increasingly faced with questions regarding family planning and population for which they need more adequate sources of information than the articles and pamphlets widely available to the lay public.

To help meet this need, the Health Committee of the North Carolina Conference for Social Service has compiled a selected bibliography on Family Planning, Population, and Religion and Birth Control.

Copies of the bibliography may be obtained free of charge from the North Carolina Conference for Social Service Office, Box 532, Raleigh, North Carolina, 27602.

NORTH CAROLINA PEDIATRIC SOCIETY

The North Carolina Pediatric Society has announced the following officers for 1966:

President—Dr. John F. Lynch, High Point
President-elect—Dr. Dan P. Boyette, Ahoskie
Secretary-treasurer—Dr. William L. London,
Durham

The Society will hold its annual meeting this year at Mid-Pines Club and Golfotel, Southern Pines, November 4-5.

NORTH CAROLINA MENTAL HEALTH ASSOCIATION

Dr. Lloyd J. Thompson of Chapel Hill received the Irene McCain McFarland Award from the North Carolina Mental Health Association at its annual banquet held in Charlotte recently.

The award is given annually to the person who has done the most for mental health in North Carolina.

Dr. Thompson, clinical professor of psychiatry at the University of North Carolina since 1960, was professor and chairman of the Department of Psychiatry at Bowman Gray School of Medicine of Wake Forest College for ten years and director of the Forsyth County Child Guidance Clinic for two years before coming to Chapel Hill.

In presenting the award to Dr. Thompson, the Rev. Orion N. Hutchinson, former president of the North Carolina Mental Health Association, listed, among others the following accomplishments:

In 1936 a special Governor's Commission published a report, "A Guide to Mental Health in North Carolina," which was Dr. Thompson's product. Also in 1936, Dr. and Mrs. Thompson took part in the reorganization of the North Carolina Mental Hygiene Society.

In 1946, the Mental Health Council, recommended in Dr. Thompson's report, was organized. He became the president of this coordinating group later.

Now retired, Dr. Thompson continues to serve as chairman of the Children's Services Committee of the North Carolina Mental Health Association. He also organized and is chairman of a similar committee for the North Carolina Medical Society.

His most recent contribution is as editor of a new publication, "Mental Health Services for Children," which is a survey of existing facilities in this field.

NEWS NOTES FROM THE NORTH CAROLINA HEART ASSOCIATION

Fourteen North Carolina scientists and laymen have been appointed members of major American Heart Association committees or councils during the current year, according to Dr. Helen B. Taussig, president of the national heart group.

From Duke University are the following appointees: Dr. Morton D. Bogdonoff—the Ad Hoc Committee on Research in the Psycho-Social and Vocational Aspects of Rehabilitation of AHA's Central Committee for Medical and Community Programs; Dr. Albert Heyman, the Coordinating Committee on Nationwide Stroke Program; Dr. Edward S. Orgain, editor of Modern Concepts, the Publications Committee of the Central

Committee for Medical and Community Programs.

Also, Dr. David C. Sabiston, Program Committee of the Council on Cardiovascular Surgery and the Committee on Congenital Cardiac Defects of the Council on Rheumatic Fever and Congenital Heart Disease; Dr. Madison Spach, Committee on Congenital Cardiac Defects; Dr. Robert Whalen, Ad Hoc Committee on Hyperbaric Oxygen Therapy; Robert L. Dickens, Finance Committee.

From the University of North Carolina School of Medicine: Dr. Ernest Craige, the Council on Clinical Cardiology; Dr. Floyd W. Denny, the Executive Committee of the Council on Rheumatic Fever and Congenital Heart Disease, as well as the Council's Committee on Prevention of Rheumatic Fever and Bacterial Endocarditis and the Ad Hoc Committee on Cooperative Study of Discontinuing Prophylaxis; Dr. Herbert S. Harned, Jr., Research Study Committee on Rheumatic Fever and Congenital Heart Disease; Dr. Louis G. Welt, the Renal Section of the Research Study Committee;

William L. Ivey of N. C. Memorial Hospital, Chapel Hill, is a member of the AHA Board of Directors; chairman of the Future Organization and Structure Committee and the Committee on Affiliate Relations and Services.

Dr. James F. Toole, of Bowman Gray School of Medicine of Wake Forest College, is a member of the Council Coordinating Committee for Community Programs, chairman of the Research Study Committee of the Council on Epidemiology, and consultant to the Coordinating Committee on the Nationwide Stroke Program.

Dr. John G. Smith of Rocky Mount, a member of the AHA Board of Directors, is also a member of the following committees: the Central Committee for Medical and Community Programs, the Council Coordinating Committee for Community Programs, the Committee on the Community Program Development Fund, and the Regional Medical Programs Committee.

Two North Carolina scientists have received research grants for the current year from the North Carolina Heart Association: Dr. Hugh J. Buford at Bowman Gray School of Medicine for "The Effect of Denervation on Fluid and Electrolyte Secretion From the Avian Salt Gland" and Dr. Irvin A. Brody at Duke University Medical Center for "Relaxing Factor in the Right and Left Ventricular Walls of the Mammalian Heart."

These grants, not previously announced, bring NCHA awards for the current year to \$104,548 and the total

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AHA-NCHA awards to scientists at North Carolina heart research centers to \$2.655.860 since 1949.

The American Heart Association also announces two special "Visiting Scientist" research awards—one of which is to Dr. Paul Leyssac of Denmark now working with Dr. Carl Gottschalk, AHA Career Investigator at the University of North Carolina School of Medicine.

NORTH CAROLINA STATE BOARD OF HEALTH

William Simpson McKimmon, Chief of the Engineering Section, Sanitary Engineering Division, North Carolina State Board of Health, retired April 1, after 36 years of service with this agency. Coming to the State Laboratory of Hygiene in 1930, he transferred to the Sanitary Engineering Division in 1933 and became chief of the Engineering Section in 1951.

Mr. McKimmon, a native of Raleigh and a graduate of North Carolina State, received a degree in mechanical engineering and a master's degree in chemistry from that institution.

Widely recognized as an authority on the water supply problems of North Carolina cities, he was awarded the George Warren Fuller Award from the American Water Works Association in 1961. In 1964 he received the Watson S. Rankin Award of the North Carolina Public Health Association for outstanding service and for the contributions he has made to the advancement of public health in North Carolina.

NEWS NOTES

Dr. Conway H. Ficklen of 306 11th Street, was installed as a Fellow of The American College of Obstetricians and Gynecologists at its Annual Meeting, May 2-5, in Chicago.

Dr. Richard J. Mountjoy, who has been a resident in dermatology in the Mayo Graduate School of Medicine, University of Minnesota at Rochester, has left that city and will be located in Concord, North Carolina.

AMERICAN MEDICAL ASSOCIATION

Four North Carolinians have been reappointed to councils or committees of the American Medical Association. The reappointments were announced by Dr. Percy E. Hopkins, chairman of the AMA's Board of Trustees.

Dr. George W. Paschal, Jr., of Raleigh, has been reappointed a member of the Council on National Security.

Dr. Thomas D. Kinney of Durham has been renamed to the Committee on Blood.

The Rev. Richard K. Young of Winston-Salem, director of the Department of Pastoral Care, North Carolina Baptist Hospitals, and the Rev. Samuel S. Wiley, executive director, North Carolina Council of Churches, have been reappointed members of the Committee on Medicine and Religion.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

The library of the National Society for Crippled Children and Adults has initiated a library photoduplication service to persons engaged in rehabilitation research. As a research project, the service is supported in part by a one-year grant of \$10,902 from the from the U. S. Vocational Rehabilitation Administration.

The service is available without charge to personnel in any educational or research institution and any health or welfare agency, public or private, who may be engaged in rehabilitation research. When a needed journal reference is not available from local resources, the person may request a photocopy from the library of the National Society.

"Rehabilitation Literature," the monthly journal published by the library of the National Society, systematically reviews and abstracts current publications. All references to journal articles indexed in "Rehabilitation Literature" are in the collection of the Society's library and are readily available for the photoduplication service. Requests for additional information may be addressed to the project director, Earl C. Graham, Librarian, National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago, Ill. 60612.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health referral and counseling programs for Armed Forces medical rejectees are now being conducted in all 50 States, Surgeon General William H. Stewart of the U. S. Public Health Service announced recently.

Under terms of the contract, the agency will screen and evaluate Armed Forces Examination Station medical records of men rejected from military service for medical reasons; counsel these young men concerning their health needs; and refer them to health and rehabilitation resources in their own communities for appropriate care.

HEALTH INSURANCE INSTITUTE

The public is making increasing use of health insurance as a means of paying hospital and medical bills, according to the Health Insurance Institute.

This is reflected not only in the increasing numbers of persons protected year after year, and amounts of benefits paid, but in the proportion of the nation's total expenditures for health care purposes paid for by insurance as well, the Institute said.

The Institute based its report on data recently released by the United States Department of Health, Education, and Welfare, and the Health Insurance Association of America.

HEW found that of the \$24.8 billion paid out by the public in 1964 for health services and supplies, insurance payments met 69% of the total hospital bills and 38% of the doctor bills in 1964. These insurance benefits were received under health insurance policies

provided by insurance companies, Blue Cross, Blue Shield, and other health care plans.

Fourteen years earlier—in 1950—comparable figures were 35% of the hospital care costs, half the 1964 proportion, and 12% for physician costs, less than one-third the 1964 proportion.

The Month in Washington

The Johnson administration wants to prohibit manufacturers from mailing physicians free prescription drug samples except when specifically requested. The administration also has proposed that door-to-door distribution of samples of over-the-counter drugs also would be banned.

The proposals are included in new drug legislation that would expand the authority and responsibilities of the Food and Drug Administration in policing drugs.

The legislation would have Congress find that:

- "(1) The mass of unsolicited samples of prescription drugs supplied to licensed practioners by manufacturers and distributors through the mails and otherwise has led to large-scale discarding and other disposal of unwanted samples which are finding their way into the hands of persons who scavenge and repack such drugs and sell them to pharmacists for dispensing on prescription in the same manner as regular stock of drugs;
- (2) Children have obtained carelessly discarded samples;
- (3) The dispensing or sale of a prescription drug sample to a patient for a fee without identification of the drug as a sample is a deceptive practice; and
- (4) The unsolicited distribution of nonprescription sample drugs directly to householders lacks minimum safeguards which would be involved in the sale of the drug in a pharmacy or other place of business.

Labels would have to read: SAMPLE DRUG. FEDERAL LAW PROHIBITS ANY CHARGE OR FEE FOR THIS DRUG."

Under the legislation, the FDA would be authorized to require records and reports of

adverse reactions and efficiency on all drugs now being marketed. Dr. James L. Goddard, Food and Drug Administration commissioner, already had ordered a review of drugs cleared before 1962.

Another provision of the legislation would "required certification of all drugs whose potency and purity can mean life or death to a patient," thus extending the law which now applies to insulin and antibiotics.

The Pharmaceutical Manufacturers Association expressed doubt that the FDA could carry out such an additional responsibility. PMA president C. Joseph Stetler said it seems "unwise to propose new areas of responsibility for an agency which has not yet proven its ability to administer" its present programs. Stetler added:

"The industry has said before that no amount of labeling can protect an individual who refuses to protect himself by ignoring his doctor's orders or the directions on the label of his medicine. Even when manufacturer and patient do everything right, an adverse reaction still is possible and medical science probably never will find a way to make it otherwise."

In a speech highly critical of the ethical drug industry at the annual meeting of the PMA, Goddard talked of irresponsibility. He said "too many drug manufacturers may well have obscured the prime mission of their industry: to help people get well."

Stetler said after the speech that he and his colleagues feared the talk "might, be interpreted as an indictment of the entire drug industry, because of its overemphasis on isolated instances, without acknowledging the integrity and responsibility which our industry has consistently demonstrated."

"It is an unassailable fact," Stetler said, "that the scientific attainments and standards of performance of the American prescription drug industry have provided an immeasurable benefit to the improvement of health and the prolongation of life."

Officials estimate that the hospitalization part of medicare will cost about \$2.3 billion in the first year of the program which starts July 1.

From the Washington Office, American Medical Association.

Benefit payments under Plan B, the medical part of medicare, are estimated at \$765 million for the first year. Premium collections—\$3 per person per month—are estimated at \$550 million, which will be matched by the federal government.

Rep. Durward Hall, M.D., (R., Mo.) reported that a poll of his constituents showed them overwhelmingly against extending medicare to all age groups. Of 13,760 persons replying to a questionnaire, 86.3% said "no" to the question: "Do you favor increasing social security taxes to finance a compulsory medical program for the entire population?" "Yes" answers totaled 11.2% and 2.5% didn't answer the question.

* * *

President Johnson has ordered that steps be taken to give rehabilitation aid to more of the disabled persons on public welfare.

In a letter to HEW Secretary John Gardner, President Johnson noted that the federal budget for fiscal 1967 would provide for vocational rehabilitation training for 215,000 handicapped persons, a 25% increase over the present year, and added:

"As we plan for the larger program I believe we should do better than we have in rehabilitating persons who are now on our public welfare rolls. In the last several years, although the absolute numbers have increased, the proportion of welfare recipients receiving training has declined from 15% to 13%. I think this trend should be reversed...

"I would like you to review the possibilities in this area and report to me with recommendations for federal and state action by June 1."

In Memoriam

Furman Payne Covington, M.D.

The staff of City Memorial Hospital of Thomasville, North Carolina, was grieved by the untimely death of Dr. Furman Payne Covington on February 1, 1966. The memory of one of the most respected and beloved members of our profession will linger long in the minds of his colleagues as well as the great host of patients and friends throughout Piedmont North Carolina.

Dr. Covington was born on February 22, 1914, in Florence, South Carolina, the son of Richard D. and Corinna Chisholm Covington. He was graduated from Thomasville High School in 1931; later attended Wake Forest College, attaining his B.A. degree in 1935; and subsequently received the degree of doctor of medicine from Jefferson Medical Collge in 1939. He served two years of internship at Atlantic City General Hospital. In 1941 he entered military service, serving with the First Division in North Africa, Sicily, and Europe. He was awarded the Bronze Star for meritorious service, and was separated from the Army to return to Thomasville on February 2, 1946.

Dr. Covington was associated in practice with Dr. R. K. Farrington from 1947 until 1951, at which time he returned to North Carolina Baptist Hospital for two years' further instruction in internal medicine. He returned to Thomasville in 1953, where he was engaged in practice until the date of his death.

Dr. Covington's death will be a sore loss to this staff, to his patients, and to this community, in that his wisdom, compassion, and untiring medical efforts will no longer be present. The load that he carried was staggering, and yet it was borne with apparent ease and perfect equanimity. He was always available to anyone who needed advice, guidance or moral support, and he seemed always to have time to talk or to listen. It is doubtful that we, as his colleagues, knew anything about the magnitude of his labors, and certainly we never heard anything of his difficulties or discomforts.

Be it resolved that these expressions of our love and respect be recorded in the minutes of the staff of City Memorial Hospital, Thomasville, North Carolina, and a copy be forwarded to his family.

Shelly C. York, Jr., M.D. George P. Highsmith, M.D. City Memorial Hospital Thomasville

Llewellyn Emil Kling, M.D.

WHEREAS, The Lenoir-Greene-Jones Counties Medical Society was deeply saddened by the death of Llewellyn Emil Kling on November 3, 1965, in Kinston, North Carolina, and

WHEREAS, he had been a devoted, faithful servant to the people of the Lenoir and Jones county areas with previous service in the Beaufort-Pamlico County areas, thereby winning special recognition by the Beaufort area Medical Society for his untiring efforts as secretary of the county society for numerous years; and

WHEREAS, Dr. Kling had distinguished himself in the field of public health with membership in many honored public health associations and prepared himself with a background including the M.P.H. degree and diploma of the National Board of Public Health and Preventive Medicine, followed by an assistant professorship of health education at Columbia University School of Public Health; and

WHEREAS, he, Dr. Kling, had been a devoted and faithful husband and father and respected member of

the Lenoir-Jones-Greene Counties Medical Society; and WHEREAS, a great vacuum is now created in our midst by his untimely departure, now therefore

Be It Resolved, that this group now express unanimously its sorrow in the loss of Dr. Kling from the community and the Lenoir-Greene-Jones Counties Medical Society, and that a copy of this resolution be sent to the North Carolina State Medical Society and to his family.

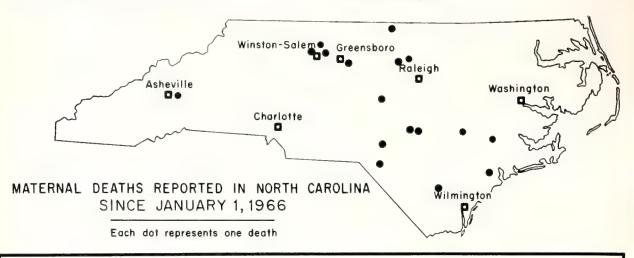
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VOLUME 27

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Paean of the Straddle Generation

President's Inaugural Address

Frank Woodson Jones, M.D.
NEWTON

The subject matter of this presentation is well called "Paean of the Straddle Generation."

We cannot hope to touch here on all the areas of interest that this Society has, nor do we have the time to comment upon all the internal matters that affect this organization. These comments do not encompass a locked-in program for 1966-1967. They are ideas for your thought and consideration, some of which we will be able to effectuate.

Our Society wisely opened its ranks to all ethical and qualified physicians several years ago. We *are* the fountainhead of medicine in North Carolina. It is to this Society that North Carolina looks for leadership in medical matters.

From the beaches near Salvo or on Hatteras in the east, to the fir-clad slopes around Patrick in the extreme western portion of this State, medicine in North Carolina is in your hands. What are you going to do with its future? If you participate actively in the affairs of your county and state medical organizations, you will have helped mold your future and our future. If you do not, then you abdicate your responsibilities, and you will not be among those who stood up to be counted on the issues when that time came—and it always does—the time to stand up and be counted.

We, my friends of the "straddle generation," whether you are 30 or 70, have had

the privilege of belonging to the most favored and interesting generation of man that this planet has ever known. We are those people who have had the opportunity of having one foot in the slower pace of other years, and yet we now straddle this amazing era of today, and we are trying valiantly to plant the other foot in the glorious possibilities of that magnificent tomorrow. It is we who are in part responsible for the possibilities of the future. Either it was our brains, our initiative, that helped create this possible tomorrow, or we seized upon and developed the thinking of our predecessors and associates in the field of science.

Change—Today and Tomorrow

Today has brought, and tomorrow will bring even more change in our attitudes and concepts. We must accept change as the inexorable dividend of progress. We must be prepared to meet such change, and although we may accept and endorse the precepts of our forefathers, we must realize that had they been confronted with today, although their basic attitude might have remained grounded in the *status quo*, their implementation and functional behavior might well have been modified.

Tomorrow brings to us the probability of the dance on the knife-edge of means and averages; the possibility of regimentation and control; the possibility of dilution of incentive; the presumption of the homogenization of man to the detriment of the uncommon man who today gives to us prog-

Read before the General Sessions, Medical Society of the State of North Carolina. Asheville, May 4, 1966.

ress. Tomorrow brings the age of the organ transplant; the time of the computers; the mechanical hearts; the yet unknown therapeutic modalities; the time also to decide when is a person truly dead.

Man is said to progress in direct proportion to his ability to move from place to place. If that be true, and there is every reason to think that such is a fair assumption, then we of this generation will have had the privilege of participating in a second dawn of man. We are truly—and again this points up the title of this address—the straddle generation. One foot is set in the 5 to 300-mile-per-hour pace of yesterday, while the other foot is seeking a toehold on the 25,000-mile-per-hour speeds of almost now, the escape velocity of tomorrow, and finally an attack upon the speed of light.

This address will be divided into two major parts. The first part will deal with the posture of this Society with reference to its relation to the greater society of man. North Carolina medicine has an obligation to its patients and to this State to propose plans and to promote ideas and programs to assist in the prevention of illness where possible; to alleviate sickness when it does occur; to counsel in matters pertaining to laws and regulations as they may affect the health of our people; to engage in an ongoing program of research, both basic and special; to organize and insist upon continuing education for those who practice this profession, the fountainhead of the healing art.

We who have seen so much happen so fast in the mid-portion of this century must continually be aware that we stand astride a fast moving stream of social, cultural, economic, scientific, political, and ideological changes. If we shut our eyes, close our ears, and forget that it was we who helped create this burgeoning new era, then this stream as it flows on could leave us standing there. This will, of course, not happen, for we feel as Ulysses did when he said, "For my purpose holds to sail beyond the sunset and all the baths of western stars . . ."

We are going to be forced, not by those people, not by government, but by ourselves

—by you and by me—to meet the issues in this changing health sphere, to solve those issues in the fashion that is best for the good of our patients and the people of our land.

Are we equal to the challenge?

These comments are, of course, philosophical. No apology is made for philosophy. Those who think are aware that man's efforts, his attainments, and his drive toward homo in excelsis are dependent upon the philosophy of some thinking man. It has been said that philosophical man does not think in a vacuum and that his most abstract ideas are conditioned by what is or is not known in the time in which he lives. To this I subscribe.

With this peroration, let us look at today and tomorrow in medicine. Let us look at our function in organized medicine. Let us look at our function as far as the individual physician is concerned. What are some of our responsibilities? What are some of our ideals? What can we do? What is presently going on that we should interest ourselves in?

Education

North Carolina has an opportunity for continuing medical education that is almost provident. From the sagacity of the present deans of our three schools, a concept of the pooling of functional continuing medical education at the supra-graduate level is developing. As a result of this, and of wise consultation and affiliation with the State Society in planning efforts, a program is being developed that could pay incalculable dividends to each of us. It might be pointed out that the schools will also benefit immeasurably in that they will have the thinking of all of the town as well as that of the gown. Each component will contribute. There are possibilities that the passage of Public Law 89-239, the Heart-Stroke-Cancer Bill, with its more palatable modifications when it was enacted, may afford an excellent vehicle for the beginning of a sophisticated continuing medical education program.

Research

The practitioners of medicine have made



FRANK WOODSON JONES, M.D.

massive contributions in this area. Research, the application of research findings, the use of allied scientific discoveries, sanitation developments, and all of the other handmaidens of health care, have conspired in the burgeoning of the health of man. It can also be said that we, by our efforts, have created a problem that faces us-that of the advancing average age of our own population. A very sobering thought arises as one ponders this question of the oldster increase. What are we doing to preserve the reasoning powers of our elders? We are creating an older populace, but are we, at the same time, attempting to preserve at an optimum level the supply of oxygen to their brain cells?

There is a further problem that surely faces us. We are delving into the nature of life itself. We are, even this day, by our research and the application of it, presenting to the greater society of man unusual situations with transcendent impact on the cultural and religious mores of centuries.

We have the means to lessen and even prohibit reproduction of this or other species; we have the means to substitute for and even implant vital organs of a mechanical nature into man. Our continuing onslaught upon the process of devitalization has begun the approach to a thinking that must eventually encompass decisions as to when is death and who shall live.

A frightening concern, and one that needs better minds than mine.

This will be, however, a part of our future.

Highway Accident Toll

We must, and we shall, take an increasing interest in highway safety. It is we who see the people who pay with life and living tissue for their mistakes and the mistakes of others.

In North Carolina in 1965, there were 1,631 deaths and 50,051 people injured on our public roads. This unnecessary morbidity and mortality are a challenge to all sectors of the public.

It is totally foolish to expect that automobiles and other motor vehicles will decrease in power. Man progresses with his ability

to move from place to place. With power comes the potential increase in speed.

We in medicine have long supported a program of built-in safety devices and safety features in motor vehicles. We are on record that there are people who are perfectly sober, law-abiding, honest citizens but who should not, because of mental or physical infirmities, be permitted to operate motor vehicles. We are in favor of regulations which make it mandatory that a vehicle be in good mechanical condition when it is used on the highways in this State. We are trained to practice preventive medicine as well as curative medicine. We believe in the concept of defensive driving. We are confronted with campaigns against speeding, drunken driving, safety measures in car construction, car inspection, driver training, and we are participating in examinations for the aged among our driving popuation. We have considered accident-prone individuals, but we have not exerted ourselves in the area of accident-prone roads and highways. More powerful cars, more drivers, and more vehicular miles will be our future.

Defensive roadways are one of the possible answers—elimination by alteration of the hazards which we have inherited in our road expansion programs. These roads meander, as Elsie the bovine wandered, over hill and dale, with no regard at all for built-in protection. We must exert ourselves and we must exert our influence in an effort of public education in this area.

Public Law 89-97—So-called Medicare Title 18

The present posture is apparently that "Medicare" patients should be handled no differently from any other individual, medically or financially, and this will be the general attitude in relations with the carrier, or fiscal intermediary, for Part B of Title 18.

Utilization under this Title is basically under Part A and should be handled by the hospital medical staff with staffing support from the administrative unit of the individual hospital. Mediation sectors, however, could be provided within the structure

of the Society at the county or state level, if a need for such sectors should develop. Patients are admitted to a hospital upon the order of a physician, are kept in a hospital upon his order, and are discharged upon his order. This is as it should be.

Title 19

This is that part of the law which has been called an "expanded Kerr-Mills." As of this date, North Carolina has not implemented this Title. You have heard, during these meetings, of an attitude adopted by the House of Delegates which could have some relation to this particular question. A fluid posture must be maintained in this area generally in order that we might move in and for the best interests of all concerned.

Relations With State and Federal Governments

A cordial and helpful relationship should and will be adopted to the end that the best interest of our patients will be served.

Other Government-Supported Programs

A concord of attitude must be maintained in all dealings in these areas.

Cults and Quacks

Medicine has the obligation to search out and point out to the public and to the government those cultists who prey upon the pocketbooks and health of our unsuspecting citizenry. It is, after all, we who have the knowledge to determine quackery. It is our duty to our patients to educate the people in these areas. This task must be done openly and it can be done on the basis of proved scientific facts totally exposed to the clear light of day.

Paramedical Careers

Medicine must concern itself seriously with the shortage of trained paramedical personnel. The health fields are being confronted on all sides by increasing demands for services. Services require more people. A point has been reached where we will be forced to train a new category of health care participants. This could be the various grades of medical and surgical technicians.

A good brain and high school education and motivation, and a subsidized program of 12 to 18 months might offer some means of alleviating the coming shortage of technical people. At the same time, we must encourage the retention and improvement of the diploma schools of nursing and promote the application of state tax funds in these areas in the same fashion that other educational fields are supported. We must also support increasing enrollment in the licensed practical nursing schools, the associate degree programs, and the professional nurse programs.

There is only one real answer, and that is to pay adequate salaries and wages. Recently the gap between pay for the health care posts and industrial wages has started to close. It is realized that such raises in salaries will increase the cost of hospital and other health care. In the competitive world of today, the public must recognize that wage scales must be met if we are to have the caliber of people needed in the health care fields, particularly the paramedical fields.

It is unnecessary to remind physicians that laboratory technicians and technologists are also in short supply.

Organized medicine in North Carolina would do well to interest itself actively in the promotion of the surgical and medical technicians' training programs.

Organizational Matters

The Annual Meeting

It seems reasonable to consider a Blue Ribbon Study Committee to evaluate the Annual Meeting of the State Society from the standpoint of:

- Clinical programs and scientific exhibits
- 2. Place or location of meetings—that is, whether access to interstate highways and airlines is more important than the facilities of a vacation-type site.

Communication

Ways and means should be devised to improve communication with the county societies regarding the issues that confront

organized medicine as they develop. These should include:

- 1. A means of making component societies aware that, almost daily, matters are handled at the state level that materially affect the private practice of the individual physician. It should be the responsibility of the county society president to provide time at each business meeting for the exchange of information and ideas, with the hope that expressions of opinions may reach from the county societies to the state level, at least through their District Councilors.
- 2. A means of acquainting the membership with definitive or significant actions of the Executive Council and Executive Committee as promptly as possible.
- 3. A provision that each county society hear a report from its own elected delegation to the Annual Meeting of the State Society at the first county meeting following the State Meeting.

Committee Structure

The elimination of non-functioning and outmoded committees must be considered. Some may be consolidated. Some may have their functions assigned to other committees. Above all, a scheme must be formulated whereby committees having a possible common interest, or a possible encroachment upon other areas, are aware of the projection of any single committee in the Society so involved, in order that each may objectively evaluate the impact of such a proposal and offer objections if need be.

There are possible solutions to this problem. One is that committees having areas that are on somewhat common ground could be grouped under one single commission. Another possibility is the creation of a Council on Economics composed of the chairman of these committees, with a commissioner or possibly one of the vice presidents at its head, in case they are not all grouped under a single commission. Programs could then be well discussed and before issues are brought back to the Council or the House of Delegates, a thorough wringing out of the

subject matter could be done. It is indeed unfortunate for the Council members to have matters dropped cold in their laps and to be expected to make a decision. It is equally unfortunate for the House of Delegates not to have pros and cons on each subject before they make those decisions of policy which will affect us immeasurably as we go along.

Councilor Districts and District Societies

In recent years the district societies have, because of a seeming lack of usefulness, but even more because they seem to have only a vague definition of purpose and function, deteriorated into a once-a-year get-together where they listen to a talk or two and then go home. At least one district has ceased even to meet.

The Constitution and By-Laws of this Society are almost mute as to the purpose of these councilor districts. Chapter VII, Section 1, of the By-Laws states: "To facilitate the organization of the medical profession, the State of North Carolina is divided into ten Councilor Districts." The chapter which follows discusses the duties of the District Councilor. Very little is said of the function of the Councilor District itself.

Today the affairs of this Society involve many issues that affect the personal and financial status of the individual practitioner and his patients. It is therefore in the interest of wisdom that we take a brief look not only at this area, but at many of the other functions and interworkings of this Society.

There is a need, however, to re-evaluate the usefulness of the District Society as an integral part of the Society operation.

To that end it is proposed:

- 1. That the Society should consider carefully a change in the By-Laws that would, in effect, stagger the elections of the Councilors and Vice Councilors in such a fashion that it would be possible for one-third of the Council to be elected each year on a 4-3-3 basis, and that they then would serve for a term of three years; and further
- 2. That a District Councilor should not

serve for more than two consecutive terms, except that after two years he might again be elected to the Council. In the case of a Vice Councilor, since he does not have a vote except when acting as a Councilor, this provision would not apply.

3. That the Councilor District Medical Societies be revitalized and have as an added concern the professional and socio-economic postures of the areas which comprise the District. Further, that the District Societies formalize themselves based upon a uniform and statewide pattern, or disband entirely as functional entities.

Conclusion

These comments relate to only a few of the widespread activities of the Society. Many areas were not touched on at all. As exam-

ples, no mention was made of the JOURNAL, cancer, headquarters facilities, legislation, mental health, and other subjects. It is certain that all the interests of this Society will be given careful consideration.

A survey form, coded, was submitted to each Society committee chairman for the 1965-1966 year. The response was gratifying and will, when the assay is complete, indicate areas for consideration in the coming year.

County society presidents will receive a communication asking for their views on Medical Society matters.

It is my hope that we will work together next year with one idea uppermost—to accomplish that which is good for medicine and and for our patients in this State.

381 Somerset Drive Newton, North Carolina

The National Blood Exchange Program

ROBERT D. LANGDELL, M.D.

CHAPEL HILL

Blood banks operate on the principle that blood used for transfusion will be replaced by members of the patient's family, by friends, or by members of the community. Although in each instance the blood used must match that of the patient, replacement is made without regard to blood type. As a result, there is usually no direct correlation between the type of blood collected and the type of blood needed. Thus on any given day a blood bank may have many units of blood on hand yet be unable to meet the needs of a specific patient. In this situation it is useful to be able to exchange with another blood bank some of the blood not needed for blood of the type in short supply.

Informal exchanges of blood between banks have been made since the early days of blood banking. One of the purposes of the National Clearinghouse Program, established by the American Association of Blood Banks (AABB) in 1953, is to make the maximum amount of blood available for patient

For editorial comment see page 309

care. The blood bank clearinghouse works much the same as a monetary clearinghouse, making it possible to exchange donor replacement credits between banks throughout the country and to facilitate lending of blood to meet unavoidable shortages or surpluses.

The Clearinghouse Program

The National Clearinghouse Program is under the operation of the American Association of Blood Banks and is implemented through five district clearinghouses. Initially these clearinghouses were separately incorporated and were more or less independent. It became apparent that for the

Read before the North Carolina Association of Blood Banks, January 15, 1965.

From the Department of Pathology, University of North Carolina School of Medicine, Chapel Hill.

program to function, ownership by the AABB was essential. Agreements to transfer ownership were negotiated, and since 1961 all five district clearinghouses have been under the operation of the American Association of Blood Banks.

The district clearinghouse is primarily a bookkeeping agency and does not ship or store blood. The district clearinghouse for North Carolina is in Jacksonville, Florida. The district office maintains daily records of the credit and blood exchanges of each bank, balances the accounts at the end of each month, and arranges settlements to cancel any resulting blood indebtedness. In order to pay the expenses of the clearing-house, a "transaction fee" of 25 cents is charged to each bank for each replacement credit or blood forwarded or received.

Although blood is the primary medium of settlement, certain fees are necessary. There are costs that the bank which ships the blood must assume in order to make the blood available. In addition to indirect costs of recruitment and processing the donor and personnel time, there are direct costs for the containers used for collection of the blood, reagents used in typing and serologic testing of the blood, and transportation. To compensate the bank which ships the blood for these costs, a standard "processing fee" of \$7.50 is charged to the account of the bank receiving the blood. If for some reason a bank is unable to settle indebtedness by shipment of blood, it can elect to pay a \$14 "donor fee." Most banks have found it more economical to settle their accounts by the shipment of blood. A license from the Division of Biologics Standards is required to ship blood across state lines, but shipment of blood within the confines of state boundaries is not controlled by federal law.

It might help to understand the exchange of blood under the clearinghouse system by a specific example. Blood Bank X finds itself in short supply of group A blood and contacts the clearinghouse office. The clearinghouse is aware that Blood Bank Z has a large amount of type A blood, and arranges for Bank Z to send 5 units of blood to

Bank X. Notice of completion of the transaction is submitted to the clearinghouse by the banks concerned. Type-specific shipments made to alleviate shortages by surpluses are considered "new order" shipments by the clearinghouse.

Once a shipment of blood between two banks has been completed, any debit or credit resulting is with the clearinghouse and not between the two banks. Thus Bank X is indebted to the clearinghouse for 5 units of blood, five processing fees, and five transaction fees. Bank Z has a credit of 5 units of blood and five processing fees, but owes the clearinghouse five transaction fees. Subsequently either bank may exchange blood replacement credits, or receive or ship several additional units of blood, to any number of clearinghouse banks.

Regardless of the number of banks exchanging blood with either Bank X or Bank Z, all debits and credits are with the clearinghouse. Once a month, each bank receives a statement from the district clearinghouse which summarizes all the transactions made by that bank during the preceding month. If the number of debits and credits are equal, they cancel out, and no settlement is necessary. If more blood is received than shipped, or more replacement credits are forforwarded than received, the clearinghouse will request the bank to settle the net indebtedness by shipping blood to a specified bank. In the first six months of 1964, there were 302,924 transactions channeled through the clearinghouse program, of which 32% required settlement.

On directed transactions (shipments made in settlement of clearinghouse indebtedness), the shipping bank is expected to ship blood less than five days after it has been collected. Unless otherwise arranged, directed blood shipments should be based on the occurrence of blood groups in the general population. The shipping bank is expected to notify the receiving bank of the type of transportation and expected time of arrival. The receiving bank may refuse a directed shipment one time, but if not accepted a second time, the indebetedness may be cancelled.

AABB-Red Cross Reciprocity Agreement

In 1961, the American Red Cross and the AABB agreed on a system of exchange between these two organizations. Although existing local arrangements between Red Cross regional and clearinghouse banks were allowed to continue, this agreement provided that all other exchanges be channeled through the AABB National Clearinghouse Office in San Francisco and the ARC Central Exchange in Washington, D. C. The AABB-ARC reciprocity agreement has been of benefit to many thousands of donors and patients.

Inspection and Accreditation Program

It is obvious that one would not want to exchange blood of known quality for blood of unknown quality. The Inspection and Accreditation program of the AABB has done much to insure the quality of blood used in the exchange program. Inspection and accreditation by the AABB is now a prerequisite for exchanging blood. Banks awaiting inspection may receive blood but must settle their indebtedness by payment of fees until fully certified.

The Inspection and Accreditation Program is available on a voluntary basis to all blood banks. It covers only those phases of blood banking engaged in by the bank seeking accreditation and is based on compliance with published standards.2 This certification program is available to all blood banks, and participation in the clearinghouse program is not a requirement. All phases of blood banking from processing of the donor to issuing the blood to the recipient are included. The program is organized on a national basis, with each of the five districts being represented. In each of the five districts of the country, there is an Inspection and Accreditation Committee which is responsible for the program in their area.

North Carolina is a part of the Southeast District, which is composed of North Carolina, South Carolina, Georgia, Florida, Tennessee, and Alabama. The members of the district committee are physicians who have an active interest in blood banking and who have direct responsibilities for accredited banks. Regional workshops are held in this district at least every two years to insure uniform inspection policies throughout the district. At the present time the chairman of the Southeast Committee is Dr. R. W. Prichard of the Bowman Gray School of Medicine. Other North Carolinians serving on the committee are Dr. Bob Andrews of Lumberton and Dr. R. D. Langdell of Chapel Hill.

Although this service has been available for several years, a disappointingly small number of blood banks in this state have become certified. It would seem desirable for every blood bank to meet or surpass the minimum standards.

Summary

There is a functioning national blood exchange program available to patients in North Carolina. A National Inspection and Accreditation Program insures the quality of blood used for exchange. Any blood bank meeting the standards may participate in this national blood exchange. District clearinghouse offices serve as accounting agencies. This exchange offers each bank a mechanism for alleviating shortages and disposing of blood found to be in excess, and also enables donors to make blood replacements locally for patients hospitalized in other areas.

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Nothing can be more absurd than to set one child to keep another; this conduct has proved fatal to many infants, and has rendered others miserable for life.—William Buchan, Domestic Medicine, or a Treatise on the Prevention and Cure of diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 37.

Red Cross Blood Procurement Program in North Carolina

INEZ W. ELROD, M.D.

CHARLOTTE

The Red Cross Blood Program was begun in North Carolina in September, 1948, when the first Red Cross blood center opened in Charlotte. Shortly afterward, a center was opened in Asheville to serve the western part of the state, and then one in Norfolk to serve Tidewater Virginia and Eastern North Carolina. In the ensuing 16 years the program continued to grow until it now serves 67 counties and a population of 3,-014,980, according to the 1960 census. Since North Carolina has a total population of 4,556,155, approximately 66% of the people of this state rely on the Red Cross for their blood needs. Last year 83,000 units of blood were supplied to the people of this state by the Red Cross.

All Red Cross blood centers are licensed by the National Institutes of Health. They are inspected annually and required to meet rigid technical standards in order to hold this license. In addition to meeting NIH requirements, each center must conform to technical standards established by the National Red Cross. Each center is under the supervision of a licensed physician, and registered nurses are employed to collect the blood.

The Red Cross Blood Program is a permissive program. This means that a Red Cross chapter may or may not elect to conduct the service. Before any of the centers serving North Carolina will provide a community with a blood service, the program must be requested and approved by the county medical society, the local hospitals, and the Public Health Service. These requests and approvals are submitted to the local Red Cross chapter, whose board decides whether the chapter can support the project. The

prerequisites include money, an organization strong enough to recruit blood donors, and sufficient volunteers to man the blood mobile visits to the community. If such support is available, the chapter applies through the Red Cross area office to the nearest blood center for admission. The program then becomes a written agreement between three parties: the local Red Cross chapter, the hospital (or hospitals) and the doctors practicing therein, and the regional Red Cross blood center. Each party has definite responsibilities.

In the centers serving North Carolina the policy is generally to meet the total blood needs of the participating hospitals and of the residents of the participating chapter areas. The blood needs of residents hospitalized outside the home chapter are met through reciprocity with the other 55 Red Cross blood centers in the United States, and through agreement with the American Association of Blood Banks. Thus Red Cross chapters in the blood program can assure blood service to the people under their jurisdiction in almost every hospital in the United States.

Each participating chapter has the responsibility of supplying a definite amount of blood determined by the amount actually used by the residents of the chapter area. It is also the responsibility of the chapter to provide a suitable site for the procurement unit, volunteer workers for various non-technical duties and suitable light refreshments for the donors.

The bloodmobile from the center then visits each community regularly according to a pre-arranged schedule. The equipment is unloaded and set up in the approved site, and nurses skilled in venipuncture techniques collect blood over a six-hour period.

To say that the chapter has previously recruited donors does not adequately express

Read before the North Carolina Association of Blood Banks. Chapel Hill, January 15, 1965.

Director, Piedmont Carolinas Blood Center.

the amount of labor and time involved. A successful bloodmobile visit requires planning, organization, and hard work on the part of the volunteer blood committee of the local Red Cross chapter. The resources of the community must be surveyed and yearly plans made for providing a specific number of donors per visit. This is done by assigning quotas to each industry or employee group, civic clubs, churches, colleges, etc. All resources are needed. In the final analysis, donor recruitment, like fund-raising, is done by having one individual ask another individual to pledge blood. These potential donors are then scheduled and are reminded of their appointment by telephone on the day of the visit.

Industries, for the most part, are readily cooperative with this type of blood program. Many of them are accustomed to releasing personnel at all hours to go to hospital blood banks to supply specific needs, or even to go in groups to out-of-town hospitals to donate blood for a member of an employee's family. Industries usually welcome a blood procurement system involving two or three planned interruptions of the work schedule yearly, with the assurance of thus meeting all needs for the entire year without further interference with production.

Regularly scheduled visits to participating chapters, with all blood being processed and shipped from the center on request to participating hospitals, result in a tremendous resource as to types and groups of blood.

An auxiliary but most important resource for blood procurement is provided by the donor files maintained by each chapter The names of donors are filed according to blood types and the files are kept up to date, so that on short notice one or more donors of a specific type may be obtained. These files make it possible to obtain blood in an emergency for the hospital if its supply from the center is not adequate. They also make it possible to obtain fresh blood when needed and to obtain large numbers of donors of a specific blood type for a bloodmobile visit when the center is low in supply of that type or when large amounts of a certain type are needed for heart surgery.

By thus using the resources of the center, plus two or more bloodmobile visits, the Charlotte Center has been able to provide 20 fresh AB negative blood transfusions for a heart operation on relatively short notice.

An important aspect of blood procurement, especially from the standpoint of the physician and the patient, is the source of donors. The control of serum hepatitis is still a real problem in blood banking, and the only presently generally accepted method of control is a careful donor history. Volunteer donors who give blood from altruistic motives are obviously more likely to give a truthful history concerning hepatitis than are donors who sell their blood and are more interested in the monetary return than in the well-being of a patient. Statistics concerning the incidence of hepatitis following transfusions substantiate this statement. All Red Cross donors are volunteers, and usually represent people with a keen sense of civic responsibility.

Not the least important aspect of the Red Cross Blood Program is its fractionation program. Because of the magnitude of the network of 56 Red Cross blood centers, it is feasible to pool the plasma from outdated or otherwise unusable blood from the centers to produce a quantity economically and technologically suitable for commercial fractionation. Last year in North Carolina, 33,-657 cc of gamma globulin were provided through its centers or through the Public Health Department, and 6,203 units of serum free by the Red Cross Blood Program albumin, fibrinogen, or other blood derivatives were supplied to hospitals in this state.

Conclusion

The Red Cross cooperative blood procurement program has proved especially successful in North Carolina, where many small hospitals and communities have combined their efforts to provide blood services possible only through a large center. The growth of the service and its expansion to include more counties each year is evidence that it meets a real need in many areas.

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Acute Diverticulitis of the Terminal Ileum

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NEW BERN

Non-Meckelian diverticulum of the ileum has been reported in the literature more frequently in recent years, but it is still considered a rather rare entity. Such a diverticulum infrequently causes symptoms, and if symptoms are present, they are rarely severe enough to warrant surgical intervention. When surgery is necessary, the surgeon is often faced with a difficult decision as to what operative procedure to perform. An unusual case of diverticulum of the ileum, its management, and the various aspects of this interesting medical entity are herewith discussed.

Case Report

In September, 1954, a 64-year-old white woman was admitted to St. Luke's Hospital, New Bern, with severe, continuous pain in the right lower abdominal quadrant of three days' duration. In addition, moderate nausea and vomiting were present. An appendectomy had been performed 20 years previously.

Physical examination revealed an acutely ill, dehydrated, elderly white woman. The temperature was 101 F, pulse rate 96, blood pressure 130/76. There was tenderness and muscle-guarding in the right lower abdominal quadrant. There was present in this area a 4-inch, tender, movable mass. Peristalsis was diminished. Pelvic and rectal examinations were negative. A flat plate of the abdomen was within normal limits. Laboratory examinations revealed a white blood cell count of 13,700, with 83% polymorphonuclear leukocytes. The red blood cell count, hematocrit, and hemoglobin levels were normal as were results of a urinalysis.

Glucose together with appropriate electrolytes was given intravenously, and a nasogastric tube was inserted. Four hours after hospital admission, an exploratory laparotomy was performed. A 4-inch intraperitoneal mass involving the distal portion of the terminal ileum and extending to the ileocecal valve was encountered. The mass was smooth, moderately firm, and indurated. The appendix had been removed. The pelvic structures were normal. Further abdominal exploration was negative except for multiple small diveticula of the descending colon and sigmoid.

It was my impression that this pathologic condition was probably due to a perforated diverticulum of the

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ileum with a resulting localized abscess. A side-toside ileo-transverse colostomy was performed. The patient made an uneventful recovery. The abdominal mass gradually decreased in size and three weeks postoperatively was no longer palpable. A barium enema study one day postoperatively revealed multiple diverticula of the sigmoid and descending colon, a functioning ileo-transverse colostomy, and a marked constriction of the terminal centimeters of the ileum. A repeat barium enema study, one month later, revealed the terminal ileum to fill readily. Another barium study, six months later revealed a discrete diverticulum of the ileum 3 cm. proximal to the ileocecal valve. In January, 1966, a complete gastrointestinal x-ray series was performed. The study showed no abnormalities except for the above mentioned ileal diverticulum, a functioning ileo-transverse colostomy, and the colonic diverticula.

The patient has remained free of gastrointestinal complaints since the operation in 1954, and now at the age of 76 years is in excellent health.

Historical Background

Sir Astley Cooper is credited with the first description of small intestinal diverticulosis in the English medical literature in 1844.¹ At postmortem examination on a man who had died of biliary cirrhosis, he found 50 small intestinal diverticula. From then to 1923 there were only 30 more such cases reported. One of these reports was by Sir William Osler² in 1881. Gordenier and Simpson³ in 1906 were the first surgeons to report seeing these lesions at surgery. The first demonstration by x-ray examination of a small intestinal diverticulum other than Meckel's diverticulum was by Case⁴ in 1920. The diagnosis was confirmed at operation.

Incidence

Site

According to Thompson and Polish,⁵ "Diverticula of the ileum are the rarest of all gastro-intestinal diverticula." Feldman⁶ estimated that the x-ray evidence of diverticulosis of the ileum was 1.5% of all diverticula of the gastrointestinal tract. According to Schnabel,⁷ diverticula appear less frequently in the small intestine below the level of the duodenum than elsewhere in the digestive

tract, and are found with decreasing incidence as the tract is descended. In 1964 Bockus¹ studied the distribution of small bowel diverticula reported by 13 different physicians from 1921 to 1958. In 487 cases of small intestinal diverticula, there were 44 cases of ileal diverticulosis, Caplan and Jacobsen⁸ state that diverticula are uncommon in the ileum and when found there are usually in the terminal segment, are small, and are inclined to be multiple. A single, isolated acquired diverticulum is most uncommon. In 1943 Benson⁹ and others recorded the experience with non-Meckelian diverticula of the jejunum and ileum at the Mayo Clinic from 1909 to 1942 and of 122 cases reported, 17 occurred in the ileum. In 1952, Baskin and Mayo¹⁰ reported 87 cases of small intestinal diverticula that were diagnosed clinically at the Mayo Clinic from 1943 to 1951. In 4 cases the lesions were confined to the ileum, and in 7 cases the diverticula were found throughout the length of the jejunum and the ileum.

Age

Diverticulosis of the small intestine can occur at any age, but it is most often found in elderly people. King¹¹ was unable to find a single example of small-intestinal diverticulosis in 5,000 necropsies in a children's hospital. Benson and others9 reported a case in a child of 13 years, however. In 1925 Baskin and Mayo¹⁰ found in their series of 87 cases that the patients were predominantly in the later decades of life. In review of 13 series of diverticula of the small intestine, Bockus¹ found that 90% of the patients were beyond the age of 40 years.

Sex

In almost all series of patients with diverticulosis of the small intestine, there is a preponderance of males. In 1964, Bockus¹ found that in a total of 487 cases reported by 13 different authors from 1921 to 1958, 61% were males and 39% females.

Association with diverticula elsewhere

A review of many series reported in the literature leads to the conclusion that if diverticulosis exists in the jejunum or ileum, there is a 25% chance that other diverticula will be found elsewhere in the alimentary tract, particularly in the colon and duodenum. In Benson, Dixon and Waugh's necrospy series of 85 cases of small intestinal diverticula, associated diverticula were found in the colon in 30 cases (35.3%), in the duodenum in 22 cases (25.9%) and in the esophagus in 2 cases (2.35%). Baskin and Mayo¹⁰ reported 59 cases of a series of 87 cases in which information concerning the condition of the colon was available. Of these 59 patients 26 (44.1%) had diverticulosis of the colon. Of their total series, of 87 patients, 22 (25.3%) had diverticula in the duodenum. Caplan and Jacobsen⁸ found that in various series reported in the literature the figures ranged from 24% to 53% for associated colonic diverticula and 22% to 44% for duodenal diverticula.

Etiology

Diverticula of the small intestine are considered to be either congenital or acquired. Multiple diverticula, which are usually found in the older age group, are generally considered to be acquired. Edwards¹² found that diverticula start just to one side of the mesentery, this origin coinciding with the perforation of the musculature by the blood vessels supplying the intestine. This is well shown by Figure 1, from Strode's article¹³ in 1955. According to Edwards,¹² weakness of the muscular wall due to the vascular supply, together with increase in the intraluminal pressure within the intestine, accounts for the diverticula.

On the other hand the congenital theory seems most logical in regard to the solitary diverticulum—usually found in the younger age group. The general picture here is of a partial reduplication of the small intestine.

Pathology

The acquired type of small intestinal diverticulum is found on the mesenteric side of the bowel. The neck of the diverticulum may be large or small. Its wall consists of serosa, mucosa and submucosa, with varying amounts of muscle strands that are attenuated. It thus appears as an outward herniation of the mucosa through the muscular

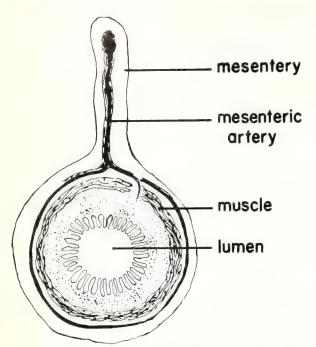


Fig. 1. Arrangement of blood supply to small intestine. (After Edwards and Strode¹³)

layer. Very rarely heterotopic tissue may be found in the diverticulum. Also, a neoplastic change has been known to occur.

The congenital type of small intestinal diverticulum is usually solitary and may be larger than the acquired type. The wall is thick and contains all the layers of the normal intestine. It also may contain heterotopic tissue and undergo malignant changes.

Diagnosis

The diagnosis of an ileal diverticulum may be made by:

- 1. Clinical features (rarely)
- 2. X-ray examination
- 3. Surgery
- 4. Autopsy

Orr and Russell¹⁴ divide patients with diverticulosis of the small intestine into three categories purely on the basis of their symptoms:

- 1. Those who have no symptoms.
- 2. Those with chronic indigestion such as vague abdominal discomfort, occasional pain, flatulence, weight loss, nausea and vomiting.
- 3. Those who suffer from an acute abdominal catastrophe due to a complication arising in a diverticulum (roughly 10%).

A fourth category has been added to the above three. This group is composed of those patients who present with mal-assimilation of various substances, including vitamin B-12, leading to macrocytic anemia. The clinical picture here is loss of weight, diarrhea, macrocytic anemia, and multiple vitamin deficiencies. Prior to 1958 Scudamore¹⁵ collected from the literature 19 cases involving patients who had diverticulosis of the small intestine in association with these symptoms. Virtually all patients with diverticulosis of the small intestine who are reported to have this syndrome had diverticula in the jejunum, although in addition some had diverticula in the esophagus, stomach, duodenum, ileum, or colon.

The complications that may arise are:

- 1. Intestinal obstruction
- 2. Inflammation
- 3. Perforation
- 4. Hemorrhage
- 5. Heterotopic tissue
 - a. Pancreatic
 - b. Gastric
- 6. Neoplastic Disease
 - a. Carcinoid
 - b. Carcinoma
 - c. Sarcoma

The x-ray demonstration of small intestinal diverticula (Figs. 2 and 3) is rendered difficult by the deep mesenteric position of the diverticula, by the usual wide neck of the diverticulum, and by their tendency to empty readily.³

Many surgeons have stated that small intestinal diverticula are not easily demonstrated at the operating table. Even though the diverticula may be distended with intestinal contents, they may offer so little resistance to the palpating hand that they are missed. Also they may be hidden in the leaves of the mesentery.

Treatment

It is generally agreed that as long as the symptoms of non-Meckelian diverticulosis of the jejunum or ileum are not too incapacitating, medical management is the treatment of choice.

Surgical intervention may become necessary when:



Fig. 2. Large diverticulum of terminal ileum that filled readily with barium enema.

- 1. The symptoms are not controlled by medical treatment
- 2. The patient cannot or will not follow a medical regimen
- 3. Complications occur

If surgical intervention is performed, there are several surgical procedures that can be employed:

- In the solitary uninflamed diverticulum, local excision gives excellent results.
- When multiple diverticula exist in a short segment of bowel, the procedure of choice is resection of the involved segment followed by an endto-end anastomosis.
- 3. If a diverticulum has perforated and a localized abscess has resulted, a short circuiting procedure may be performed, as in the case here reported (Figs. 4 and 5).
- 4. When diverticula are found in all or the major portion of the small intestine, resection of the bowel in which the largest diverticula are located, or in which obvious complications are seen, should be performed.

In general, surgical treatment usually offers excellent results. The trend today is that surgical intervention should be under-



Fig. 3. Colonic diverticulum of ileum demonstrated by barium enema.

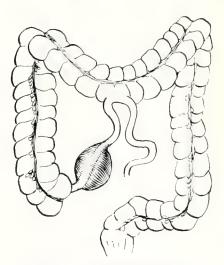


Fig. 4. Operative procedure.

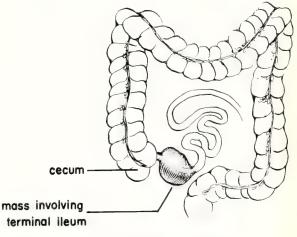


Fig. 5. Findings at operation.

taken only in those cases in which severe complications have occurred.

Summary

A case of a solitary perforated diverticulum of the ileum with abscess formation that was treated by an ileo-transverse colostomy is reported. The various aspects of ileal diverticulosis are discussed. Medical management of this clinical entity is advised, and surgery is recommended only in those cases in which serious complications have occurred.

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Complications with the Use of Intrauterine Devices

Report of Two Cases

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EDENTON

In March, 1964, it was decided to add intrauterine devices (IUD) to the other contraceptive practices available to patients at the Maternal Health clinics of Chowan and Perquimans counties. The device was offered to selected patients who it was felt lacked the sustained initiative to continue taking oral contraceptives but who needed and desired some kind of birth control.

In the selection of cases, the patient's preference for this type of contraceptive was of primary consideration. It was offered only to those who had had at least one child. For the highly motivated, more intelligent patients we recommended oral medication, and we encouraged the grand-multiparous women who were over 35 to

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have surgical sterilization. Tables 1 and 2 summarize our experience with the devices at the two clinics from May, 1964 to November 23, 1965.

Two cases, one involving uterine perforation and the other pregnancy with the device in situ, are reported below.

Case Reports

Case 1

A 20-year-married Negro woman, gravida III, para II, abortion O, was delivered of a child on March 21, 1965. She did not want another pregnancy and preferred an IUD over other methods of contraception. On May 22 a Lippes loop was inserted without apparent difficulty. The patient was advised to return for evaluation in one month, after her next menstrual period. Three days later she returned with her husband, who had a gonococcal infection, and was given 5 cc of bicillin prophylactically. At this time the device was noted to be in normal position.

The patient did not return again until July 20, 1965, when she complained of malaise, swelling of the lymph nodes of the neck, and fever (101.2 F).

Table 1

Experience with IUD in Chowan and Perquimans Counties

Clinic No. 1

(May, 1964-November, 1965)

	No. Case
Device inserted	62
Device removed or expelled and re-inserted	7
Device expelled and not re-inserted	4
Patients became pregnant with device in sit	u 1
Patient became pregnant after expelling device	e 2
Patient moved from clinic jurisdiction	3
Patient overdue in clinic	6
Patients active in clinic	53^*
*Includes patients overdue in clinic	

She was given 1 cc of penicillin and told to return the next day. At that time it was noted that the loop strings were not palpable, and the device was thought to be out of place. An x-ray was advised. She returned to the clinic on July 31 for the x-ray, and the IUD was located on the right side of the abdomen and was thought to be outside the uterus.

The patient was admitted to the hospital Aug. 2. A sound was admitted into the uterus and x-rays were made, confirming the position of the IUD outside the uterus, in the right lower quadrant of the abdomen. The patient was afebrile and free of pain. The next day she underwent an exploratory laparotomy, and the loop was removed from the abdominal cavity. There was a small, fresh-appearing perforation of the right mid-portion of the fundus of the uterus measuring about 0.25 cm in diameter. Her recovery was uneventful.

Case 9

A 24-year-unmarried woman, gravida IV, para III, came to the clinic on April 27, 1965, requesting contraceptive advice. She expressed a preference for an IUD. She stated that her last menstrual period was March 29, 1965. On physical examination her pelvis was thought to be normal and a Lippes loop was inserted. When she failed to return for evaluation, a nurse made a home visit on June 9. The patient reported that she had had what seemed to be a normal menstrual period, but had not menstruated since. She came to the clinic on July 27, reporting that menstrual bleeding had been irregular and scanty. The loop strings were not palpable and x-rays were advised. The films indicated enlargement of the uterus and location of the IUD, turned upside down, in the lower portion of the uterus.

The patient returned on August 13 with a complaint of spotting, and was advised of her regular examination at the Maternal Health Clinic. She was not seen again, however, until November 10, when she came to the office and asked that the IUD be removed, as she was having abdominal cramps. This request was denied and she was again urged to return to the Maternal Health Clinic.

On November 16, 1965, she was admitted to the

Table 2

Experience with IUD in Chowan and Perquimans Counties

Clinic No. 2

January, 1965-December 7, 1965

No.	Cases
Device inserted	57
Patient changed to another method	2
Device removed or expelled and re-inserted	3
Device expelled and not re-inserted	2
Patient became pregnant with device in situ	0
Patient became pregnant after expelling device	0
Patient moved from clinic jurisdiction	1
Patients overdue in clinic	0

hospital in labor, and before the baby's head appeared, she expelled the device. The baby, weighing only 3 pounds 1 ounce and calculated to be from 28 to 30 weeks' gestation, did very well. Following the delivery the mother was surgically sterilized at her request.

Summary and Conclusion

Two cases representing complications attending the use of intrauterine devices, one involving uterine perforation and the other pregnancy with the device *in situ*, are presented.

Despite the potential gravity of these complications, those of us engaged in the Chowan-Perguimans Maternal Health clinic have continued to use the devices for selected patients because of certain unique advantages which they hold over other methods of contraception. These patients are from low-income groups living under the poorest home conditions. They lack privacy for inserting jellies or vanishing cream, and several have complained that they had no place to keep oral medications from small, active youngsters. Others found it difficult to keep the tablets separate from drugs for tuberculosis or asthma being taken by other members of the family. In our case the IUD had the advantage of being (1) the patient's choice, (2) relatively simple to insert, and (3) relatively inexpensive.

Continuing into modern times, the progress of medicine has inevitably depended on human experimentation for the final acceptance of any new procedure. The necessity of such experiments and the safeguards with which they should be surrounded have been repeatedly emphasized since Claude Bernard's simple pronouncement that "those that can only harm are forbidden, those that are innocent are permissible, and those that may do good are obligatory."—Editorial: Experimentation on Man, New Eng J Med 274: 1382, June 16, 1966.

Significance of the Blood White Cell Count in the Diagnosis of *Hemophilus influenzae* Meningitis

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It is commonly assumed that in bacterial infections the peripheral blood white cell count is elevated and the polymorphonuclear leukocytes are increased. It is not so well recognized that this is not the case in the important problem of infections due to the *Hemophilus influenzae* organism in infancy. It was decided to review the significance of the blood white cell count in the early diagnosis of patients with *H. influenzae* meningitis admitted to the Pediatric Service of the North Carolina Baptist Hospital. A brief and interesting case history illustrates the problem.

Case Report

An 11 1/2-month old white male infant was admitted to the emergency room with a history of one day of fever rising to 104.6 degrees. He was lethargic, but there were no other complaints. Physical examination revealed only a lethargic infant with a temperature of 104.6 F. No meningeal signs were elicited. His white blood cell count was 11,000, with 36% segmented neutrophils, 4% bands, and 60% lymphocytes. A lumbar puncture revealed clear, colorless spinal fluid, with no cells, under normal pressure. He was sent home and seen again the following morning because of the persistence of fever and lethargy. He was then admitted to the hospital.

On admission the child was obviously acutely ill, the only positive physical finding being possible nuchal rigidity. The lumbar puncture was repeated 14 hours after the first one, and grossly cloudy spinal fluid was obtained. The Pandy reaction was 3 plus; protein measured 110 mg/100 ml and sugar 38 mg/100 ml. There were 1400 white cells/cu. mm, of which 84% were segmented.

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Gram-negative pleomorphic organisms were seen on the gram stain and were confirmed on culture. The patient improved rapidly on intravenous treatment with chloramphenicol and sulfisoxazole. He was discharged after 14 days in the hospital.

Comment

It is obvious that the blood white cell count in this patient did not suggest bacterial infection. For this reason a review of the patients in the hospital with a diagnosis of H.

Table 1
Initial Blood White Cell Count in Patients with
H. Influenzae Meningitis

	II. Illiachz	ac members	
Age	WBC	Segs	Bands
1 mo.	3,800	20	23
114 "	6,000	34	-
13/4 ''	5,000	23	4
2 "	5,000	23	30
2	6,000	37	9
212 "	4,000	15	— (expired)
21/2 "	28,000	48	11
312 "	55,000	78	5
4 "	15,000	51	5
5 ''	10,700	47	4
5 ''	12,000	70	_
6 ''	3,200	36	4 (expired)
612 "	17,000	65	_
612 "	22,000	63	_
7	9,000	64	8
71,2 "	36,000	79	_
8 ''	12,000	45	_
10 ''	7,600	56	8
11 ''	11,000	74	_
14 ''	11,300	27	41
16 ''	12,000	46	33
18 ''	9,800	38	2
19 ''	13,500	70	7
20 ''	30,000	33	17
20 ''	11,000	69	_
24 ''	20,600	75	3
24 ''	12,500	36	4
27	5,000	54	5 (expired)
30	16,000	78	
30 ''	11.000	52	9
36	7,800	56	8
5 years	12,500	74	19
7	17,600	83	5

influenzae from the years 1956 through 1964 was made. Thirty-three cases in which *H. in*fluenzae meningitis was diagnosed by positive culture were found. The white cell counts on admission of these patients are recorded in Table 1; a wide range of counts was obtained. Twenty-seven per cent of the patients had a white cell count greater than 15,000. Thirty-six per cent had a total peripheral white count of less than 10,000. Of the 7 patients who were less than three months of age, only 1 had a count of over 6,000. Of those who were less than three months of age, only 2 had counts of less than 6,000. Both died. This finding suggests that in patients more than three months of age having H. influenzae meningitis, a total blood white cell count of less than 6,000 is a poor prognostic sign.

These findings are similar to those of Stiehm's study involving meningococcal infection (1966),¹ in which a normal or low blood white cell count was considered to be associated with a grave prognosis.

Pediatricians accustomed to seeing H. influenzae know that the peripheral white blood cell count may not be elevated in this disease. Physicians who are less familiar with it, however, may place too much importance on the blood white cell count as an indication of bacterial disease in infancy. Thus a delay in diagnosis may be made in a disease that requires early and vigorous therapy.

Summary

A review of the initial blood white cell counts in patients with *H. influenzae* meningitis suggests that they may be of no value in alerting the physician to the possibility of a fulminating bacterial disease. Second, white cell counts below 6,000 in patients more than three months of age are a poor prognostic sign.

Acknowledgement

The author is grateful to Dr. Weston M. Kelsey for permission to review these patients and for his help in reviewing the manuscript.

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REVISED RULES FOR ADMISSION TO THE TAR HEEL CORONARY CLUB

It has been estimated that North Carolinians belong to some 17,000 civic, social, fraternal and church-related organizations of local, state and national scope. But there is one "organization" which probably has the largest membership in the state—the "North Carolina Coronary Club."

The North Carolina Heart Association offers Timothy Tarheel some revised rules for admission to the state's Coonary Club.

The rules get right down to the heart of the matter—and for those who do not know anything about the Coronary Club, it is that large body of North Carolinians who have suffered premature heart attacks.

- (1) A promising candidate has to make resentment part of his life. Make sure you have a positive grievance, a real chip on your shoulder.
- (2) Never smoke less than 50 cigarettes (preferably more) per day. A mild cigar in the evenings is no substitute.
- (3) A man who can afford a bottle of whisky per day—is a ground floor candidate.

- (4) Make sure you add a few pounds to your body weight each quarter. An ambitious candidate must put up with shortness of breath. The bullneck and hippobelly are excellent qualifications.
- (5) Keep your nose near the grindstone. Take work home in the evenings—seven nights a week. Make yourself so tired that you need a sedative. Cut down that holiday! An idler won't be admitted here.
- (6) Eliminate walking—it's a waste. Go everywhere on wheels. Put effort into your leisure. Don't let yourself relax. You owe it to your employers. Make your games a science. Never play golf without business talks at the same time. Rush! Rush! Rush!
- (7) Cut out the optimism. Let your mind dwell on tax problems. Remember the Internal Revenue Service is out to get you. Keep the H-bomb well in mind. Work up a nice obsession about the state of the world.

If you fulfill these main qualifications for getting into the Coronary Club, the North Carolina Heart Association can't guarantee Timothy Tarheel will be admitted, but the application will be kept on file.

I knew an eminent physician who used to say that he made his children dance instead of giving them physic. It were well if more people followed his example.—William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 40.

Report on Trauma

EARLY CARE OF INJURED HANDS

Of all of the complications which can occur following major and minor injuries of the hand and fingers, stiffness of the interphalangeal joints is the most difficult to correct and the most serious as far as limiting the possibilities of future restorative surgery. It follows, therefore, that preservation of interphalangeal joint function should be a prime objective in early treatment and that any hand which reaches the stage of secondary treatment with supple joints has been superbly managed.

The frequently emphasized, but often neglected, position of function has seemed only to assure that when joints become stiff they will be in a natural position. Although joints which are stiff in a natural position are decidedly better than joints which are stiff in an unnatural position, the restorative potential for many hands will never be realized until the concept of continual preservation of motion replaces the concept of immobilization in any position. It is especially dangerous to immobilize hands which are edematous, as joint capsules, collateral ligaments, and other fibroelastic structures are unusually subject to the ill effects of immobilization when soaked in serum. Once the elastic components of the interphalangeal structures have been replaced with unvielding fibrous tissue, the pathogenesis of their injury has passed a critical point which is extremely difficult to reverse.

Successful wound closure is the most important defense against prolonged edema; all wounds of the hand should be closed as rapidly as possible. To leave a wound open intentionally because cleansing and debridement were of doubtful adequacy is not good judgment, in our opinion. Such wounds can always be "dressed" with a thin split-thickness skin graft which needs to be sutured by only a few sutures placed at strategic points.

Submitted by the Committee on Trauma, North Carolina Chapter of the American College of Surgeons.

Reprinted from the North Carolina Medical Journal, Vol. 24, September, 1963.

In summary, the early treatment of all types of hand wounds should be designed to protect and preserve function of the interphalangeal joints. To this end, avoidance of immobilization by rigid fixed splints and bandages and the prevention and treatment of edema by elevation and early closure of soft tissue wounds are the most important basic principles which apply to all types of injuries. Complications such as malunited or ununited fractures, unrepaired or dehisced tendons and nerves, or less than optimal surface scars can be handled satisfactorily as a secondary procedure, provided normal function of the interphalangeal joints has been preserved.

New Booklet on Cancer

"The Cancer Story," a booklet prepared by the National Cancer Institute for the general reader to explain the nature of cancer, how it is diagnosed and treated, and how science is learning more about it has been issued by the Public Health Service.

Single copies of "The Cancer Story" may be requested free of charge from the Public Health Service, Washington, D. C. 20201. Copies may be purchased from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. The price is 25 cents each, with a discount on quantities over a hundred.

Increase in Medical and Dental X-rays Reported

The number of Americans exposed to medical and dental x-rays increased from about 100 million in 1961 to more than 108 million in 1964, a nation-wide x-ray exposure study by the Public Health Service has indicated.

The growth, which exceeds the population increase for the same period, does not reflect the increasing complexity of many medical x-ray examinations and treatments, explained Dr. Richard H. Chamberlain of Philadelphia. At the same time, he said, "a major purpose of the study was to find out where we can improve the efficiency of x-ray usage in medicine so that maximum diagnistic value is obtained with a minimum of exposure to the patient."

Dr. Chamberlain, professor of radiology at the University of Pennsylvania and chairman of the Public Health Service Medical X-ray Committee, was moderator of a five-man panel which reported on the findings of the second phase of the PHS survey to the convention of the American College of Radiology held in Chicago recently.

The North Carolina Heart Association is a member of the North Carolina Health Council.

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June, 1966

MEDICAL ECONOMICS AT THE CROSSROADS

One of the historic precepts of medicine has been the traditional custom of members of the profession to use their talents for the benefit of those in need without thought or expectation of material compensation from those without resources. New federal legislation, specifically Public Law 89-97, Title XIX, establishes a system whereby states participating in medical as-

sistance programs will by 1970, be required to provide customary and reasonable fees for services rendered beneficiaries.

On the one hand, such a system may tend to dilute the gratitude of the patient, who, knowing that payment is provided by government, will expect service as a right; while, on the other hand, it may dry up for the physician that spiritual "oasis" of inner satisfaction that stems from help freely given to the grateful patient truly in need. Efforts to expand the mantle of federal health care, already planned, will inevitably compound this dilemma.

J.S.R.

BLOOD PROCUREMENT IN NORTH CAROLINA

Blood has been used in this state far longer than one might suspect. The Transactions of the 19th annual meeting, held at New Bern in May, 1872, contain an account by Dr. J. Francis King of Wilmington of a transfusion of lamb's blood into a patient with tetanus. Despite additional heroic treatment with large doses of whiskey, the man died. Dr. John Elliott, in Salisbury, had one of the earliest plasma programs in the country in the 1930s. In the current issue Drs. Elrod and Langdell present facts on two of the most important ways in which blood is presently provided to North Carolinians. Since there is no central compilation of data on blood banking, it is hard to say what percentage of the blood transfused in the state is accounted for by these systems. Certainly the potential for both the AABB Clearinghouse system and the Red Cross program is large, and interested parties need to constantly keep looking into their own methods and to seek help from these groups as needed.

There are several other blood procurement systems active in the state. The first, also the oldest and most primitive, is the "walking" blood bank, in which previously tested blood donors are called in when their type of blood is needed. Many of our smaller hospitals rely on this means. Such a system does not provide the "buffering" which

comes from having a goodly supply of blood at hand when emergencies arise, and when emergencies do arise, it taxes the facilities of the hospital to include donor bleeding in the list of things which must be done.

An intermediate system is one in which blood usage in a hospital is large enough to maintain a supply of blood of all types, replaced usually from several sources. Foremost among these sources is the family and friends of the person who got the blood. Other sources are "professional" donors in the community, or blood bought from one of the many commercial blood banks which operate in various areas of the country. The net expense of running such a system is probably the greatest of any of the plans so far described, and there is evidence that blood bought from at least some commercial blood banks is associated with a higher incidence of serum hepatitis than blood procured from families and friends of the patient. It is worth noting that virtually all blood given in North Carolina comes from volunteer donors, who should be the keystone of any good blood procurement plan.

Finally, there is the idea of predeposit of blood, constituting a blood assurance plan. There are many examples of such plans across the nation, but few in North Carolina. One of these, the Wake County Blood Procurement Plan, Inc. has more than 5000 subscribers, and although relatively early in its development, has been quite successful in obtaining an adequate supply of blood to meet the needs of its subscribers. Such plans are often supported by large industrial firms, and sought out by them when they open plants in an area.

This brief discussion of blood procurement would not be complete without mention that procurement is only one phase of blood banking. The proper stewardship of blood, like that of money, has many requirements. Casual observation of blood banking practices in various hospitals of different sizes around the state shows that nationally accepted methods in blood banking are often not used, even though they are not difficult or arbitrary. It does not matter whether a blood bank supplies ten

units per year or ten thousand, that blood must be the best possible in all aspects.

As an aid to blood banks, the American Association of Blood Banks maintains an inspection and accreditation service, with volunteer, unpaid committee members who do the inspections and make recommendations after a thorough survey of the bank. The service is given without charge to members, and membership fees are based on the amount of blood transfused per year. It is a worthwhile thing to look into, for blood banking is one of the most sensitive areas of medical practice from the legal and moral points of view.

* * * DOWN'S SYNDROME

There has been more interest in Down's syndrome recently, not merely occasioned by the adoption of the eponym to replace the term mongolism, with its unfortunate connotations, but through biochemical and chromosomal studies. There are at least four, and probably more, basic disorders which express themselves in the clinical picture of Down's syndrome, with such familiar features as mental retardation, characteristic facies, and liability to congenital heart disease and leukemia. The most common form (about 95% of cases) is associated with increased age of the mother at the time of conception, possibly with increased paternal age as well; in this type there is an extra chromosome 21 (trisomy). There are two forms in which pieces of chromosome 21 attach themselves to other chromosomes; to one of the number 13-15 chromosomes in one case, and in the other to chromosome 21. These two are the so-called translocation types, and are uncommon, accounting for 3-5% of cases of Down's syndrome. The very rare case in which the chromosomes appear normal by present methods presents a continuing problem in methods of chromosome study.

In this issue of the JOURNAL (p 311) Dr. Harold Goodman of Bowman Gray asks the physicians of the state to put him in touch with the families of any children with Down's syndrome in which other cases have occurred, indicating that they may have a

translocation type of the disease. Since only about 10% of the patients with this disease are in institutions, and often without adequate histories, there is not much chance of locating significant numbers of these patients without the help of the physicians in private practice who know them and their families. Since it is important for such families to know of the increased likelihood that other cases of Down's syndrome will occur in families with this form of the disease, and since the services of Dr. Goodman's group are without cost to the families, it is hoped that his appeal will bring some response.

OH TO BE IN CANCER, NOW THAT SPRING IS HERE!

As the dogwood begins to bloom one can rest assured that newspapers, newsmagazines and television programs will soon bear the latest news from the cancer front. Flushed from their dens (sometimes, we suspect, quite willingly) come various research workers to tell about their activities. In many cases there is a ring about what they say that is reminiscent of the cry of hide-andseek, "Ready or not, here I come;" for past experience tells us that this is the last which will be heard of the work, and it would likely be better not heard. The hopes of cancer patients are temporarily buoyed up, physicians are beleaguered by patients, families, and friends of patients, to contact someone who has appeared in one of the news media about taking care of their particular case. When contacted, the research man is usually found to be not taking calls. About the time the blooms begin to fall and no new ones appear, the cancer news slackens and the world goes on its way.

Statisticians, noting a very high correlation between these reports on cancer and the arrival of spring, might conclude that the growth stimuli so evident at that season were behind the talkativeness of cancer researchers. As with so many such associations which can be dreamed up, they would be on the wrong track. The cause is both apparent and somewhat venal. This is the time for the fund-rasing drive of the American Cancer Society, and not too far away from the presentation of budget requests to the Congress. Powerful stimuli these, in an age of publicity, and not to be resisted by the most retiring of scientists. In fact, the retiring scientist may be a vestigial figure, doomed to extinction by selection in favor of the talkative scientist. Like other products of natural selection, the new flackotropic breed will have to stand the test of time or be replaced himself. Who knows—he may be all right.

THE DIAGNOSIS OF OLDIEOSIS IN THE MALE

Much has been made of a remark, attributed to a student on the Berkeley campus of the University of California, that members of his generation had learned that no one over 30 years of age can be trusted. Little attention has been paid to how the students and others in their age group and younger can tell when someone has passed the mark and entered the age of deviousness. Investigation among the junior and senior high school set here in North Carolina indicates agreement with the philosophical basis of the Berkeley remark, and also indicates the diagnostic criterion they use for males. When the hair is combed backward for the forehead from any point anterior to the vertex, the man is an "oldie." In checking their observations on actors whom one knows to have passed the 30 mark, one notes that they have heeded the observational powers of the youthful audience to which they all seem to play, and have taken to combing their hair forward. It is not necessary that the hair reach the eyes (or chin) as is the case with some musical groups; it is the direction that counts. Perhaps those among us who value such diagnostic pearls will find use for this latest one—if their practice is not among actors.

If a child be gorged by food at all hours, and enticed to take it by making it sweet and agreeable to the palate, is it any wonder that such a child should in time be induced to crave more food than it ought to have? —William Buchan: Domestic Medicine, or a Treatise on the Prevention and Cure of Disease by Regimen and Simple Medicines, etc. Philadelphia, Richard Folwell, 1799, p. 34.

Schedule of Committee & Commission Appointments

Schedule of Committee and Commission Appointments—1966-67

NOTE: The Committees listed herein have been authorized by President Frank W. Jones, M.D., and/or are required under the Constitution and By-Laws.

Particular note should be taken of the authorization of the House of Delegates of a Commission form of organizational activity and that all Committees, excepting Committee on Nominations, Committee on Negotiations, and Mediation Committee, are segregated under the respective Commission in which the function of the committee logically rests. This will tend to eliminate overlapping and duplication in activity programs and result in coordination of the work of the Society in a manner to lessen the work of the delegates in the Annual Meeting of the House of Delegates.

(The President, Secretary and Executive Director of the Society are ex-officio members of all committees and, along with the Commission Chairman, should receive notice of meetings, agenda and minutes of Committee meetings during the activity year.)

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31. Committee on Military Dependents Medical Care

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Box 157, Sunbury (1st)

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Leonard Palumbo, M.D.32

N. C. Memorial Hospital, Chapel Hill (1966) (et esq.)

A. Hewitt Rose, Jr., M.D.92

2009 Clark Avenue, Raleigh (1967)

Robert W. Williams, M.D.65

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Dula Hospital, Lenoir
Robert A. Pascal, M.D.¹²
Valdese General Hospital, Valdese
Theodore D. Scurletis, M.D.⁹²
State Board of Health, Raleigh
D. A. McLaurin, M.D.⁹² (Consultant)

Box 36, Garner

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Duke Hospital, Durham Leonard Palumbo, M.D.³²
N. C. Memorial Hospital, Chapel Hill Ernest H. Yount, Jr., M.D.³⁴
Bowman Gray, Winston-Salem

Consultants:

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(O&O) Richard B. Rankin, Jr., M.D.¹³ Box 3295, Concord (Surg) Patrick F. Clark, M.D.¹¹

401 Doctors Building, Asheville (Pd) William J. DeMaria, M.D.³²

Duke Hospital, Durham

(ObG) John H. Monroe, M.D.34

415 N. Spring Street, Winston-Salem

(PH&E) Sarah T. Morrow, M.D.41

Guilford County Health Department, Greensboro

(N&P) Robert N. Harper, M.D.⁹² 2109 Clark Avenue, Raleigh

(Rad) Leslie M. Morris, M.D.36

Medical Building, Gastonia

(Path) A. Wendell Musser, M.D.³²

Duke Hospital, Durham

(Anes)

(O&T) J. Frank Hamilton, Jr., M.D.¹¹
283 Biltmore Avenue, Asheville
(SAMA) Joel E. Rothermel³²
14 South Circle Drive, Chapel Hill

45. Committee Advisory to Student AMA Chapters in North Carolina (15) II-8

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John P. Davis, M.D.34

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46. Ad Hoc Committee on Task Force on Title XIX— (SSA) (8) IV-8 George W. Paschal, Jr., M.D.,⁹² CHAIRMAN

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Kernodle Clinic, Burlington
Robert A. Ross, M.D.³²
N. C. Memorial Hospital, Chapel Hill
David G. Welton, M.D.⁶⁰
1012 Kings Drive, Charlotte
Frank W. Jones, M.D.¹⁸ (ex officio)
Rt. 3, Westlake Hills, Newton

1110 Wake Forest Road, Raleigh

47. Utilization Committee (11) IV-9

H. Fleming Fuller, M.D.,54 CHAIRMAN Kinston Clinic, Kinston
Roy S. Bigham, Jr., M.D.60
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Robert Perry Crouch, M.D.11
Central Medical Building, Asheville
Barry H. Hawkins, M.D.13
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103 Doctors Building, Asheville
Warner Wells, M.D.³²
N. C. Memorial Hospital, Chapel Hill

48. Advisors to: North Carolina Association of Medical Assistants (2)

Hugh E. Tyner, M.D.³⁶ 815 W. Mauney Avenue, Gastonia Philip Naumoff, M.D.⁶⁰ 1012 Kings Drive, Charlotte

49. Representatives on: Governor's Coordinating
Council on Aging (1)
Edger T. Reddingfield, Ir. M.D.98

Edgar T. Beddingfield, Jr., M.D.⁹⁸ (term expires June 30, 1969) Community Clinic, Stantonsburg

50. Committee on Radiation (1)
 Robert J. Reeves, M.D.³² (1969)
 Duke Hospital, Durham

51. Committee on Appalachia

Until we as a people. can recover or discover for ourselves some similar source of natural respect for the aged (''filial piety''), I doubt that our programs of geriatric care will solve the central problem of mental and apiritual serenity as well as physical health and comfort. With money and man power ,we can rescue the aged from poverty, but how—except by a change in our basic convictions about community life—can we rescue the aged from our own indifference toward them and from their own sense of usefulness?''—From an interview with Walter H. Judd, M.D., on Chinese Attitudes Toward the Elderly-Geriatrics 21: 115 (June) 1966.

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50 - 59	70.00	160.50	192.00
60 - 64*	110.00	246.00	277.50
	PLAN B-\$300	DEDUCTIBLE	
		Member	Member, Spouse
Age	Member	and Spouse	and Children
Under 40	\$ 19.00	\$ 43.50	\$ 57.50
40 - 49	29.00	67.50	81.50
50 - 59	45.50	97.50	111.50
60 - 64*	69.00	154.50	168.50
	PLAN C-\$500	DEDUCTIBLE	
		Member	Member, Spouse
Age	Member	and Spouse	and Children
Under 40	\$ 12.00	\$ 26.50	\$ 35.00
40 - 49	19.50	45.50	54.00
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Bulletin Board

COMING MEETINGS

New Hanover County Medical Society Symposium— Blockade Runner Hotel, Wrightsville Beach, August 12-13.

North and South Carolina Societies of Ophthalmology and Otolaryngology, Joint Meeting—Sheraton Motor Inn, Winston-Salem, September 11-13.

North Carolina Association for Retarded Children—Jacksonville, September 16-17.

Charlotte Postgraduate Seminar—Presbyterian Hospital, Charlotte, September 21-22.

Forsyth District Medical Society Meeting—The Country Club of North Carolina, Pinehurst, October 5.

University of North Carolina School of Medicine, Conference for the Non-Psychiatrist Physician on "Grief and Depression—Their Crisis Management"— Chapel Hill, October 6-8.

North Carolina Academy of General Practice, 1966 Scientific Assembly—Hotel Jack Tar, Durham, October 27-29.

North Carolina Society for Crippled Children and Adults, Annual Convention—Mid Pines Hotel, Southern Pines, October 28-29.

Society of Nuclear Medicine, Southeastern Chapter—Jack Tar Hotel, Durham, November 3-5.

NEW MEMBERS OF THE STATE SOCIETY

Dr. Lucien Martin Strawn, Or, Cape Fear Valley Hospital, Fayetteville; Robert S. Darrow, P, 15 2nd Ave., N.E., Hickory; John Richard Corbett, R, Cape Fear Memorial Hospital, Wilmington; Robert Eugene Hammonds, Otol, Ardsley Road, Concord; Robert A. Whisnant, Oph, Cabarrus Medical Building, Concord; George Alfred Engstrom, Pd, Ardsley Road, Concord; Charles Preston Nicholson, Jr., 1002 Arendell St., Morehead City; Edward Everett Anderson, U, 1 Winthrop Court, Durham; Edward Frederick Doehne, III, P, 102 Christopher St., Chapel Hill.

Also, Drs. Harold Sylvester Pride, GP, 2204 Beatties Ford Road, Charlotte; Lloyd Harrison, GP, Warrenton; Carl Augustus Furr, Jr., ObG, 2 Ardsley Road, Concord; Lillian Louisa Rich, North Fork Road, Black Mountain; Francis Cushman Whitlock, 406 Broad St., New Bern; John Cotten Tayloe, Jr., 405 Medcalf St., New Bern.

Also, Drs. Gladston Wesley Allen, ObG, 1804 Murchison Bldg., Fayetteville; Henry Bryan Dixon, II, 1029 Wellington, High Point; Charles Clinton Griffin, Jr., Cove Infirmary, Greensboro; Kaissar Sleimen Ibrahim, S., 713 Wilkins St., Smithfield; Emery Louvelle Rann, GP, 1001 Beatties Ford Road, Charlotte; Joseph Franklin Cowan, 1115 East Nash St., Wilson; George Roy Walker, Jr., P., 904 Stagecoach Road, Chapel Hill; James Wallace Esler, Jr., Anes, N. C. Memorial Hospital, Chapel Hill.

Also, Drs. Harold Allen Myers, Lake Toxaway; Dewey Hobson Yarley, I, 731 Broad St., Durham; Ariadna Irma Kivirand, Path, Box 9506, Oteen; James Blackerby, GP, 1807 Tryon Road, New Bern; Joel Leonard, GP, 15 E. 2nd Ave., Lexington; William Octavius Dobbins, III, GP, VA Hospital, Durham; Thomas H. Williston, GP, 246 Page Ave., Gastonia; Harris Lane Evans, P, 624 Quaker Lane, High Point.

Also, Drs. Joseph D. Weaver, III, N. Maple St., Ahoskie; James Slater Simmons, GP, 711 Wall St., Sanford; Donald Edgar Swift, Oph, Box 217 Aberdeen; Jay Frederick Lewis, II, Path, James Walker Memorial Hospital, Wilmington; Thomas E. Buie, Jr., P, 2204 Hawkins St., Raleigh; Angus Sinclair Dunn, Main St., Cherryville; Wade Frederic Heritage, 225 Hill Road, Southern Pines; Milton Flahe Campbell, Int. Res., 220 Woodridge Drive, Durham.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. Eben Alexander Jr., professor of neurosurgery at the Bowman Gray School of Medicine, was installed as president of the Harvey Cushing Society April 21 at the 34th annual meeting of the organization in St. Louis, Mo.

Organized in 1932 with 30 charter members, the Harvey Cushing Society, the official organization of neurological surgeons in the United States, now has a membership of more than 1,000. Eighteen North Carolinians are members.

Dr. Alexander, chief of professional services at North Carolina Baptist Hospital for the past 13 years, has served as secretary and treasurer of the society. He was elected president-elect in 1965 and succeeded Dr. Francis Murphey, professor of neurosurgery at the University of Tennessee School of Medicine, as president.

Dr. Alexander is also a member of the editorial board of the Journal of Neurosurgery, the official publication of the society, and recently was appointed editor of the journal's section on neurosurgical techniques.

Promotions for 23 members of the faculty of the Bowman Gray School of Medicine have been approved by the trustees of Wake Forest College. The promotions will become effective July 1.

Promoted to the rank of professor were Dr. Courtland H. Davis, Jr., neurosurgery; Dr. Carolyn C. Huntley, pediatrics; Dr. Carlos E. Rapela, physiology; and Dr. Henry L. Valk, medicine.

Promoted to the rank of associate professor were Dr. Ivan W. F. Davidson, pharmacology: Dr. Adam B. Denison, physiology: Dr. Donald M. Hayes, medicine; Dr. Laurence B. Leinbach, radiology; Dr. Samuel H. Love, microbiology; Dr. Edwin H. Martinat, orthopedics and physical medicine-rehabilitation; Dr. Herman E. Schmid, Jr., physiology; and Dr. Frederick L. Thurstone, biomedical engineering.

Promoted to assistant professor were Dr. Jean D.

Acton, microbiology; Dr. Bill C. Bullock, laboratory animal medicine; Dr. Clair E. Cox, urology; Dr. David L. Kelly Jr., neurosurgery; Dr. John R. Kennedy, anatomy; Mrs. Eva S. Leake, microbiology (research); Dr. Henry C. O'Roark II, obstetrics and gynecology; Dr. J. William Rogers, ophthalmology; and Dr. L. Earl Watts, medicine.

Part-time faculty members who received promotions were Dr. I. Gordon Early and Dr. Paul L. Garrison, both to assistant professor of clinical medicine.

Dr. William H. Boyce, professor of urology, in April was named the first Vest Visiting Professor at the University of Virginia. The visiting professorship in urology was established in memory of Dr. Samuel Alexander Vest, former professor and chairman of the Department of Urology at the University of Virginia School of Medicine.

During the three-day program, which began April 21, Dr. Boyce spoke at medical grand rounds on "Current Status of Research and Thearpy of Urinary Calculi" and at surgical grand rounds on "Neurogenic Bladder: New Ideas for Management" and "Diagnosis and Management of Urinary Outlet Obstruction in Children."

Dr. Felda Hightower, associate professor of surgery, was installed as president of the North Carolina Chapter, American College of Surgeons, during the 10th annual meeting of the chapter April 14-16 in Winston-Salem. Dr. Hightower, who was elected president-elect in 1965, succeeded Dr. Alexander Webb of Raleigh as president.

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, was re-elected secretarytreasurer of the Southeastern Psychiatric Association at the annual meeting of the organization April 24-27 in Southern Pines. He is a past president of the association.

Dr. Clark E. Vincent, professor of sociology and director of the Behavorial Sciences Center at the Bowman Gay School of Medicine, has been appointed to the Mental Health Training Committee of the National Institute of Mental Health. His four-year term will begin July 1.

Dr. Vincent will serve on the subcommittee for pilot and special projects and public health. The group reviews applications for training grants in these fields and conducts site visits to training centers applying for grant support.

Wilbur S. Avant Jr., a junior medical student at the Bowman Gray School of Medicine, was presented the 1966 Neurology Essay Award at the annual meeting of the American Academy of Neurology April 25-27 in Philadelphia. The contest is conducted annually by the organization and is open to all medical students in the United States and Canada.

Avant's prize-winning entry was entitled "Pulsatile

Echoencephalography: A Review and the Importance of the Respiratory Factor." The paper is based on his findings during two summers of work as a Student Reseach Fellow in the Sonics Laboratories of the medical school. It reported for the first time the effects of the respiratory factor in diagnostic ultrasound His research was conducted under the supervision of Dr. William M. McKinney, assistant professor of neurology.

Three members of the Bowman Gray faculty participated in a conference on "Sex in Marriage: Some New Clinical Approaches" April 16-17 in Kansas City, Mo.

Dr. Clark E. Vincent, professor of sociology, discussed "Problems of Marital Infidelity." Dr. Eugene B. Linton, assistant professor of obstetrics and gynecology, conducted an interview in a "Simulated Case of Sexual Maladjustment in Marriage." Mrs. Ethel M. Nash, assistant professor of preventive medicine and president of the American Association of Marriage Counselors, opened the conference and presided at a panel discussion on "Merits and Demerits of Marriage Manuals."

While in Kansas City, Dr. Vincent, also delivered the banquet address for the Groves Conference on Marriage and the Family held April 19.

* * *

Darrell P. Thorpe, senior student at the Bowman Gray School of Medicine, received the Outstanding Student Paper Award at the annual meeting of the North Carolina State Medical Society in Asheville.

The award, which includes a \$50 prize, is given annually for the best scientific paper presented during the session for Student American Medical Association Chapters at the state medical society meetings.

Thorpe, whose paper was entitled "Positive Weil-Felix Reactions in Juvenile Rheumatoid Arthritis and Acute Rheumatic Fever," represented the Bowman Gray School of Medicine in competition with students from Duke University School of Medicine and the University of North Carolina School of Medicine.

Dr. Weston M. Kelsey, professor and chairman of the Department of Pediatrics, presented two papers at an April 19 meeting of the Tennessee Diabetes Association in Gatlinburg, Tenn. His topics were "Simplified Concepts in the Management of the Initial Treatment of the Acidotic Juvenile Diabetic" and "Problems in Managing Teen-Age Diabetics."

Dr. Norman M. Sulkin, professor and chairman of the Department of Anatomy, spoke at a recent meeting of the Laboratory Animal Breeders Association in Chicago. His topic was "Animal Resources for Gerontological Research."

* * *

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, presented a paper on "A Drug Treatment of Depressive States" at the annual meeting of the Southeastern Psychiatric Association April 24-27 in Southern Pines. Five members of the Department of Anatomy of the Bowman Gray School of Medicine presented papers at the annual meeting of the American Association of Anatomists in San Francisco, Calif. They were Dr. Walter J. Bo, professor; Gene L. Colborn, graduate student; Dr. D. Louise Odor, associate professor; Mrs. Dorothy Sulkin, research assistant; and Dr. Norman M. Sulkin, professor and chairman of the department.

Thirteen papers, prepared at the Bowman Gray School of Medicine, were presented at the 50th annual meeting of the Federation of American Societies for Experimental Biology April 11-16 in Atlantic City, N. J.

Presenting papers were Dr. Camillo Artom, pofessor emeritus of biochemistry; Dr. Bill C. Bullock, instructor in laboratory animal medicine; D. Hugh J. Burford, assistant professor of pharmacology; Dr. Thomas B. Clarkson Jr., professor and director of the Department of Laboratory Animal Medicine; Eugene R. Heise, graduate student in microbiology; Dr. Charles D. Hendley, associate professor of pharmacology; and Dr. Noel D. Lehner, postdoctoral trainee in laboatory animal medicine.

Also, Dr. John E. MacNintch, postdoctoral trainee in biochemistry; Dr. J. A. Pascual, postdoctoral trainee in physiology; Dr. Robert S. Pool, assistant professor of pathology; Dr. Robert W. Prichard, professor of pathology; Dr. Robert W. St. Clair, postdoctoral trainee in biochemistry; and Dr. Franklin Young, research instructor in medical genetics.

Dr. Harold D. Green, professor and chairman of the Department of Physiology, served as chairman of a federation session on "Blood Pressure."

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Two prominent Tar Heel laymen have established a unique organization to be known as "Medical Student Aids Anonymous."

Its purpose is to provide funds to help worthy students over the financial bumps on the road to a medical degree at the University of North Carolina.

Members agree simply to honor a \$20 draft on their bank accounts each month. Anyone may join.

A membership card is being designed as a tangible evidence of participation in the new organization. * * *

A physician's hobby has been converted into a gift worth more than \$20,000 in cash to the University of North Carolina School of Medicine.

The physician, a UNC medical graduate, donated his stamp collection to the Medical Foundation of North Carolina "to advance the interests of the UNC School of Medicine."

The collection, consisting mostly of stamps from the British colonies, was auctioned in London, England.

The auction already has benefited the medical school in the amount of \$20,000 and an additional \$2,000 is expected.

Attention was focused on sexual problems of the newly married at a medical symposium on May 21-22.

The two-day symposium was sponsored by the University of North Carolina School of Medicine, the N. C. Medical Society's Committee on Marriage Counseling, the N. C. State Board of Health and the American Association of Marriage Counselors.

Dr. Robert A. Ross, former chairman of the UNC Department of Obstetics and Gynecology and now professor in the department, was banquet speaker.

* * *

Two University of North Carolina psychiatrists have been elected chairmen of committees of the Group for the Advancement of Psychiatry (GAP).

Dr. Morris A. Lipton is chairman of the Committee on Research and Dr. David R. Hawkins is chairman of the Committee on Medical Education. Both are on the psychiatry faculty of the UNC School of Medicine.

G.A.P. is composed of about 250 psychiatists organized into 21 committees. Meetings are held twice each year to discuss current topics of interest in psychiatry.

G.A.P.'s most recent report, and the one provoking the most widespread reaction, was issued by the Committee on the College Student. It was entitled "Sex and the College Student."

The early detection of certain diseases which attack the nervous system and muscles will be one of the aims of a new research project at UNC School of Medicine.

The National Institute of Neurological Diseases and Blindness has awarded a three-year grant totaling about \$50,000 for a study of "In Vitro Lymphocyte Reactions in Neuromuscular Disease."

Dr. Charles E. Morris, UNC neurologist, is the principal investigator and Dr. Ira Fowler, UNC anatomist, is the co-investigator.

Diagnostic tests now available for patients with multiple sclerosis, polyradiculoneuritis, or polymyositis are helpful only to a limited extent. The new research project is designed, in part, to improve the diagnostic tests for the three disorders so patients may have help early in the course of their diseases.

One of the most immediate applications of computers in medicine is getting and processing physiological data, a University of North Carolina computer scientist said recently.

"This is making medicine better much more quickly than anything else," Dr. Ralph W. Stacy said.

Dr. Stacy spoke before some 20 members of the Central Carolina chapter of the Association for Computing Machinery which met on the UNC campus.

He explained that the processing of physiological data usually involves small, fast computers with several special features such as an ability to translate from electrical signal to numbers as well as visual display.

A professor of bioengineering and biomathematics in the UNC Medical School's department of surgery, Dr. Stacy suggested that the computer also take over many of the complex technical and administrative jobs in hospitals.

North Carolina's newspaperwomen were offered a first-hand look at medical matters during a day-long meeting at the University of North Carolina School of Medicine here May 14.

The program for the North Carolina Press Women ran the gamut from alcoholism and ambulances to mammography and the menopause.

This was the first medical meeting conducted at UNC specifically for newspaperwomen.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

A Duke University Medical Center physician is one of 10 obstetricians who will share \$450,000 in grants over the next three years from Josiah Macy, Jr. Foundation.

He is Dr. Carlyle Crenshaw, an assistant professor of obstetrics and gynecology who now is on a two-year leave of absence while studying mother and child physiology at Yale University.

Dr. Crenshaw will rejoin the Duke faculty July 1, at which time he will become head of the mother-child physiology segment of the department of obstetrics and gynecology research program.

Dr. Ewald W. Busse, chairman of the Department of Psychiatry at Duke University Medical Center, has been elected vice president of the American Psychiatric Association.

In addition to this new position, Dr. Busse is secretary-treasurer of the American Board of Psychiatry and Neuology, a member of the residency review committee of the American Medical Association, and a member of the Governor's Advisory Council on Aging.

* * *

Dr. Eugene A. Stead, Jr., chairman of Duke University Medical Center's Department of Medicine, has been selected as a committee member for an extramural study at the Mayo institutions in Rochester, Minn.

Dr. Stead is one of eight leaders in medical and general graduate education invited to serve on the committee which is reviewing the educational facilities and activities of Mayo Foundation, Mayo Clinic and the Mayo Graduate School of Medicine.

The study is concerned with immediate and long range objectives of the Mayo educational program.

The National Cystic Fibrosis Research Foundation has renewed a grant to the Cystic Fibrosis Regional Care, Research and Teaching Center at Duke University Medical Center.

A check for \$27,333 was received by Dr. Alexander Spock, director of the center, from Wilbur Barrow, president of the Raleigh-Durham Cystic Fibrosis chapter.

Duke is one of 36 regional cystic fibrosis centers

in the United States. All have been established with the help of the National CF Research Foundation and are maintained with its continuous support.

Lectures in Sweden, Denmark and France, and side trips to Czechoslovakia, Switzerland, Holland and Austria, comprise this summer's itinerary for Dr. D. C. Tosteson, chaiman of the Depatment of Physiology and Pharmacology at Duke University Medical Center.

Dr. Tosteson will deliver lectures on a subject in which he has done much research—the role of sodium and postassium ions in regulating the volume of cells and their composition.

His first stop will be in Sweden, where he will lecture before the medical faculties of universities in Uppsala, Lund, Stockholm and Gotenburg. From there he will go to Denmark for a lecture at the University of Aarhus. This will be followed by a lecture visit to the Laboratories De Genetique Physiologique at Gif-sur-Yvette, France.

The side trips planned will take him to a conference on membrane processes in Smolenice, Czechoslovakia, and to the laboratory of famed Professor J. P. Posternak at the Institute De Physiologie De L'Universite, Geneva, Switzerland. He also will visit laboratories in Utrecht, Holland, and attend the second International Biophysics Congress in Vienna Sept. 5-9.

Two Duke University Medical Center staff members have been elected officers of the North Carolina chapter of the Health Physics Society.

* * *

They are Dr. Aaron P. Sanders, an associate professor of radiology, the new president-elect, and Conrad M. Knight, radiological safety officer, who has been named secretary-treasurer.

The new president is L. T. Caruthers, Jr., radiological safety officer at North Carolina State University.

The health physics group is devoted to the protection of man and his environment from unwarranted radiation exposure.

Dr. Philip Handler, chairman of the Department of Biochemistry at Duke University Medical Center, has been elected to the American Academy of Arts and Sciences.

Dr. Handler, who is on sabbatical leave from Duke until September, also is James B. Duke Professor of biochemistry.

An allotment of \$74,107 for the student loan fund at Duke University School of Medicine has been made by the United States Public Health Service for fiscal year 1967.

The funds are for loans to full-time students studying at one of the schools which meet the requirements of the federal Health Professions Student Loan Program. Students in need may borrow up to \$2,000 for an academic year.

The school which receives the allotment has the responsibility of administering the loans to the students. The loans are paid back to the school over a 10-year

period which begins three years after a student completes or terminates his course of study. Interest accrues on the loan only during the repayment period. **

Ray E. Brown, director of the Duke University Graduate Program in Hospital Administration, has been appointed a member of the advisory committee for demonstration grants recently established by the United States Public Health Service.

The committee is responsible for the preliminary review of applications for demonstration grants, experimental construction grants, and area-wide planning grants in the field of hospital and medical facilities.

ANNOUNCEMENT

A group of investigators at the Bowman Gray School of Medicine ask your help in locating patients with Down's syndrome who may have one of the translocation types of this disorder. A large proportion of patients who have a sibling, cousin, or paternal or maternal relations with the same disorder are translocation types.

Please notify Dr. Harold O. Goodman, Department of Preventive Medicine and Genetics, Bowman Gray School of Medicine, Winston-Salem, if you have treated or know of such families. Contact with the families will be established only through notifying physicians. Studies of chromosomes and of metabolic abnormalities will be undertaken without cost to subjects.

NORTH CAROLINA STATE BOARD OF HEALTH

The State Board of Health has elected Dr. Jacob Koomen, State Health Director, and Dr. W. Burns Jones, Jr., Assistant State Health Director. Each had been filling these offices in an acting capacity since January 1 of this year when Dr. J. W. R. Norton resignes this position for health reasons.

Governor Dan K. Moore gave his cordial approval to both of these public health leaders and made the official announcement. In accordance with legal requirements, election by the Board is subject to approval by the Governor.

A native of Bristol, New York, Dr. Koomen was graduated from the University of Rochester School of Medicine. He came to North Carolina in 1954 and became Assistant Director of Epidemiology in 1956, received his Master of Public Health Degree from the

University of North Carolina School of Public Health in 1957 and became Assistant State Health Director in 1961.

Dr. Jones was graduated from The Citadel, received his M.D. degree from the Medical College of South Carolina and his Master of Public Health degree from the University of North Carolina School of Public Health. He came to his present place from the position as director of the Local Health Division.

AMERICAN MEDICAL ASSOCIATION

Dr. Elias S. Faison of Charlotte, has been reappointed a member of the Committee on Nursing of the American Medical Association.

The AMA Committee has as its primary purpose the maintenance of high standards of patient care in the preventive, curative, and restorative aspects of illness. The Committee maintains that optimal patient care depends upon a harmonious, collaborative relationship between medicine and nursing. In an effort to protect and foster an enduring alliance between these two major health professions the Committee on Nursing has instituted a continuing program of liaison, communication, education, and research.

AMERICAN MEDICAL WRITERS' ASSOCIATION

"The Changing World of Medical Communication" will be the theme of the American Medical Writers' Association annual meeting to be held at the Waldorf Astoria, New York City, Thursday, September 29 through Sunday, October 2, 1966.

A varied program of panel discussions, round tables, workshops, and plenary sessions is being organized by the Program Committee under the chairmanship of Dr. Alexander B. Gutman and co-chairmanship of Miss Martha Dana. Registration is \$15.00 for non-members; free to members. Preliminary programs will soon be available from the National Office of A.M.W.A. at 2000 'P' Street, N.W., Washington, D. C. 20036.

North Carolinians should lower their dietary fat intake. A diet high in saturated fats increases the risk of heart attack, says the North Carolina Heart Association.

More persons died from heart and blood vessel disease in North Carolina during 1965 than from all other causes *combined*, says the North Carolina Heart Association.

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BOOK REVIEW

Death and Dying: Attitudes of Patient and Doctor. Symposium No. 11, Group for the Advancement of Pcychiatry. 75 pages. Price, \$1.50. New York: Mental Health Materials Center, 1966.

Probably the most frustrating and ego-depleting experience of the physician is that of caring for the dying patient. Confirmation is found in the continually appearing books and papers concerned with the care of the dying patient.

This particular symposium, conducted by those who should be able to provide us with the most definitive data available, does just this. It is unfortunate that the most definitive data extant offer little that is new or different. The first of the five papers is a cursory view of mortality data as related to age, sex, race, socio-economic status, etc. The second paper deals with attitudes toward death in relation to cardiovascular disease, the third with such attitudes as related to neoplastic disease. The fourth and fifth papers deal with attitudes toward death in general.

One finding of interest is reported: While the majority of patients with a fatal illness would prefer to be told of it, the majority of physicians believe they should not be told. Perhaps this discordance of opinion should hold some significance for

the physician. There also is general agreement among these essayists that the factor causing the greatest anxiety in the dying patient is fear of isolation or abandonment because of his illness. These two items of interest were buried deeply within a bog of psychiatric jargon. One would doubt whether it is worth the time of the average practicing physician to dig for such bits of information when they are much more readily accesible elsewhere.

Eaton Laboratories Lists Teaching Films in New Catalog

Fifty-three medical and surgical films, in full color and sound available at no charge from Eaton Laboratories, Division of the Norwich Pharmacal Company, are described in a new illustrated film catalog which can be obtained from Eaton sales representatives or the Eaton Medical Film Library.

Produced by Eaton Laboratories, the running times of the films vary from 10 to 30 minutes. Each film demonstrates a specific surgical, medical, diagnostic or laboratory procedure in the fields of urology, plastic and reconstructive, burn therapy, gynecology, opthalmology, or cardiovascular surgery.

Requests for the free 64-page catalog or for film showings can be made to Eaton sales representatives or by writing to the Eaton Medical Film Library, Eaton Laboratories, Norwich, New York, 13815.

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The Month in Washington

The importance of the role of the general practitioner is emphasized in the recommendations of the National Commission on Community Health Services to President Johnson.

The Commission said that everyone should have a personal physician, even under the group practice system. Under these conditions, the commission added, group practice should be stimulated. It is essential that physician-patient relationship strengthened "if comprehensive personal health services of high quality for each individual are to be achieved," the commission said.

"The long range import of the recommendation of having the personal physician assume responsibility as the central source for preventive health service and continuing care, most particularly its impact on medical education, is well appreciated.

"The possibility of attracting a sufficiently large number of medical graduates to careers as personal physicians presupposes a general recognition of the importance of the role and commensurate rewards in professional satisfaction and income comparable to that of other physicians. In all its ramifications, the national effort must be comparable in magnitude to that which expanded medical research personnel in the last two decades. Large scale financing will be necessary for the support of teachers, students, facilities, programs, and educational research."

Other commission recommendations included: breaking down eventually all separate systems of health care such as for veterans, labor members, merchant seamen, and the medically indigent; orienting all health care services on a community basis.

The commission is a private, non-profit study group formed in 1962 by the National Health Council and the American Public Health Association, Thirty-two members from medicine, business, labor, and other fields make up the commission, which is headed by Marion B. Folsom, former Secretary of Health, Education and Labor.

"To achieve an integrated program which will provide comprehensive personal health services of high quality to all in each community, it will be necessary to weld together many separate programs into a communitywide program," the commission said. "Accomplishment of this goal would preclude new construction or the expansion of hospitals for these separate groups, and would require total integration of such facilities into the total community services. Financing . . . will continue to come from a variety of resources."

The National Academy of Sciences-National Research Council will undertake for the Food and Drug Administration a new evaluation of the efficacy of about 4,000 prescription drugs, starting this summer.

"The determination of the efficacy of new drugs marketed from 1938 to 1962 is called for under the Kefauver-Harris Amendments of 1962," Dr. James L. Goddard, FDA Commissioner said.

"I am grateful that the National Academy, with its capability of calling upon the talents of the nation's most distinguished scientists is willing to accept this important public responsibility."

The review will be the most extensive efficacy study of drugs ever undertaken, Goddard said. Results of the study will guide the FDA in its final determination of the effectiveness of the drugs.

C. Joseph Stetler, president of the Pharceutical Manufacturers Association, commended the selection of the academy for the task.

"PMA is delighted that this method was selected," Stetler said. "Based on past activities, we are certain that the academy will work with both industry and medical practitioners in forming guidelines for determining the effectiveness of these products."

"Although this undertaking will be of extraordinary magnitude for an Academy-Research Council advisory study, it is also one of extraordinary importance to the medical profession and the nation," Dr. Frederick Seitz, NAS-NRC president said. "It is essential that the study have the strongest possible professional base; we shall, therefore, depend on the cooperation, not only of many individual medical scientists, but also of the major professional societies interested in therapeutic drugs."

Since October, 1962, manufacturers have been required under the Kefauver-Harris Amendments to submit substantial evidence to support therapeutic claims before receiving FDA approval to market a new drug. The NAS-NRC review will put to the efficacy test new drugs marketed under the provisions of 1938 legislation, which required only a showing that drugs were safe for their intended use. The 1938 Act excluded from FDA approval procedures drugs already on the market, as well as drugs introduced after that date that were generally recognized as safe by qualified experts.

Dr. James Z. Appel, president of the American Medical Association, sharply criticized the FDA's enforcement of the 1962 Drug Act Amendments.

"The manner in which the Agency suddenly seizes drugs and accompanies this activity with alarming language tends to create an atmosphere of hysteria," Appel said. "It also is creating a restrictive and undesirable medico-legal climate that will inevitably exert a deleterious influence on the effective use of drugs by the physician. This trend is causing the medical profession much concern . . .

"Nagging us is the increasing suspicion that regulatory decision may be dictated more by the technicalities of regulatory language than by appeal to competent medical and scientific analysis and judgment. The tame submission of the pharmaceutical industry to any and every regulatory suggestion or directive, regardless of the medical and scientific facts involved, is unsettling . . .

"At the time of the passage of the 1962 amendments and subsequent regulations, we were concerned about the advisability of non-medically oriented lay FDA inspectors being permitted to inspect and copy the case records of physicians engaged in clinical investigation. This could only result in a non-professional acting as a judge in a profes-

sional area and also invading the physician-patient relationship. We have been apprised of incidents where such inspection has extended even to the personal file of an investigating physician. The future implementing of this aspect of drug investigation cannot help but concern us."

The AMA has reiterated its support of a federal program to aid in modernization of hospitals.

Dr. F. J. L. Blasingame, executive vice president of the AMA, wrote the Senate Health Subcommittee that the AMA supports that provision of an Administration bill (S. 3009) that would provide grants and loans for modernization of hospitals and other medical facilities, through direct federal loans, government guarantee of private loans, and also federal grants with respect to loans, amortizing principal and interests payments thereon up to 40% of the cost of a project.

"While the present Hill-Burton program does provide for modernization of hospital facilities with priority in the case of projects for modernization of facilities, to facilities serving densely populated areas," we nevertheless feel, because of the great need which exists, that the special program contemplated under S. 3009 for modernization of facilities in metropolitan areas is indeed warranted," Blasingame said.

The AMA opposed some other provisions of the legislation. It was recommended that aid for diagnostic or treatment centers be eliminated and that federal money be available to only those public health centers operated by a public health department.

In Memoriam

Thomas Stringfield, M.D.

Thomas Stringfield was born September 9, 1910, to Samuel Lanier and Addie Sloan Stringfield, the first of five children born of this marriage. His father and uncle were physicians in Waynesville before him. Medicine was truly "in his blood."

Educated in Waynesville Township High School, he attended Virginia Military Institute and was graduated from Wofford College. His first two years of medical training were received at the University of North Caro-



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lina School of Medicine and he was graduated from the Medical College of South Carolina. He interned at Watts Hospital in Durham, North Carolina, and then began the practice of medicine in his home community in association with his father.

With the onset of hostilities in Europe he felt an urge to be of service and volunteered as a physician with the Duke University unit of the American Red Cross, stationed in England. Upon the entry of the United States into the conflict he was commissioned a Lieutenant in the United States Navy Medical Corps, serving with distinction for over four years in the Pacific theater with active participation in the invasion of several of the Pacific islands. At the conclusion of the war he returned to Waynesville and resumed the general practice of medicine.

In 1943 he was wed to Miss Harriett Cutter Coburn of Asheville. Three children were born of this union, Mary Love, Samuel Coburn, and Ann Cutter Stringfield. In 1953 he was joined in practice by his brother, James King Stringfield, adding another to an already long line of skilled physicians. This association was continued until death overtook him.

Thomas Stringfield's virtues were legion, his short-comings difficult to find. Devoted father, he took an active interest in his children's development and activities. Attentive husband, his home was one of peace, happiness, and mutual respect. A Rotarian, he served actively as director and president of the Waynesville Club. Actively interested in the Boy Scouts of America, he supported it whole-heartedly, in many positions, including that of Chairman of the Pigeon River District of the Daniel Boone Council. A lifelong Methodist he actively supported his church in many capacities, and his life daily reflected his faith to all around him.

A sense of humor served him and his patients well.

He firmly believed in looking for and expressing openly the good qualities he saw in his fellow man. This characteristic endeared him to the people he served and to his fellow physicians who held him in highest esteem.

Thomas Stringfield's life was not an easy one. He knew adversity, but he was an example of patience and strength, living life one day at a time with courage. Above all, he continued to grow until life's end. Stricken with tuberculous infection of the central nervous system, he bore this affliction with his customary patience and cheerful disposition, losing the battle and departing this life to life on a higher plane on April 24, 1966.

His fellow physicians of the Haywood County Medical Society know that they have lost a true friend in the deepest meaning of the word. They are thankful for his life and hereby resolve that his memory shall serve as a source of inspiration as they strive to emulate him.

They further resolve that a copy of this expession be sent in deepest sympathy to his widow and childen, and to the North Carolina Medical Journal for publication in his memory.

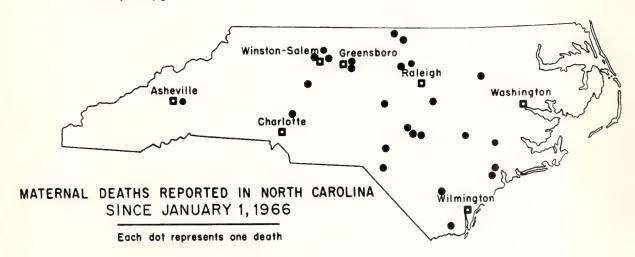
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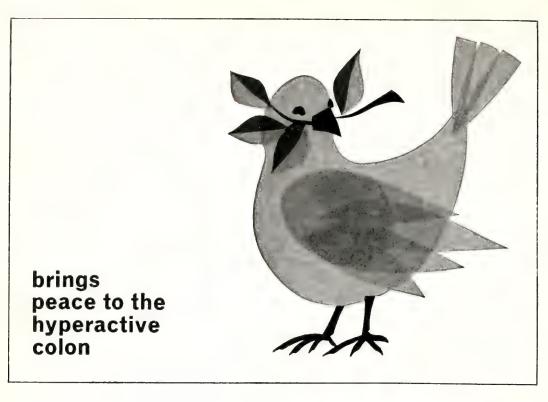
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1. Riese, J. A.: Amer, J. Gastroent, 28,541 (Nov.) 1957

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